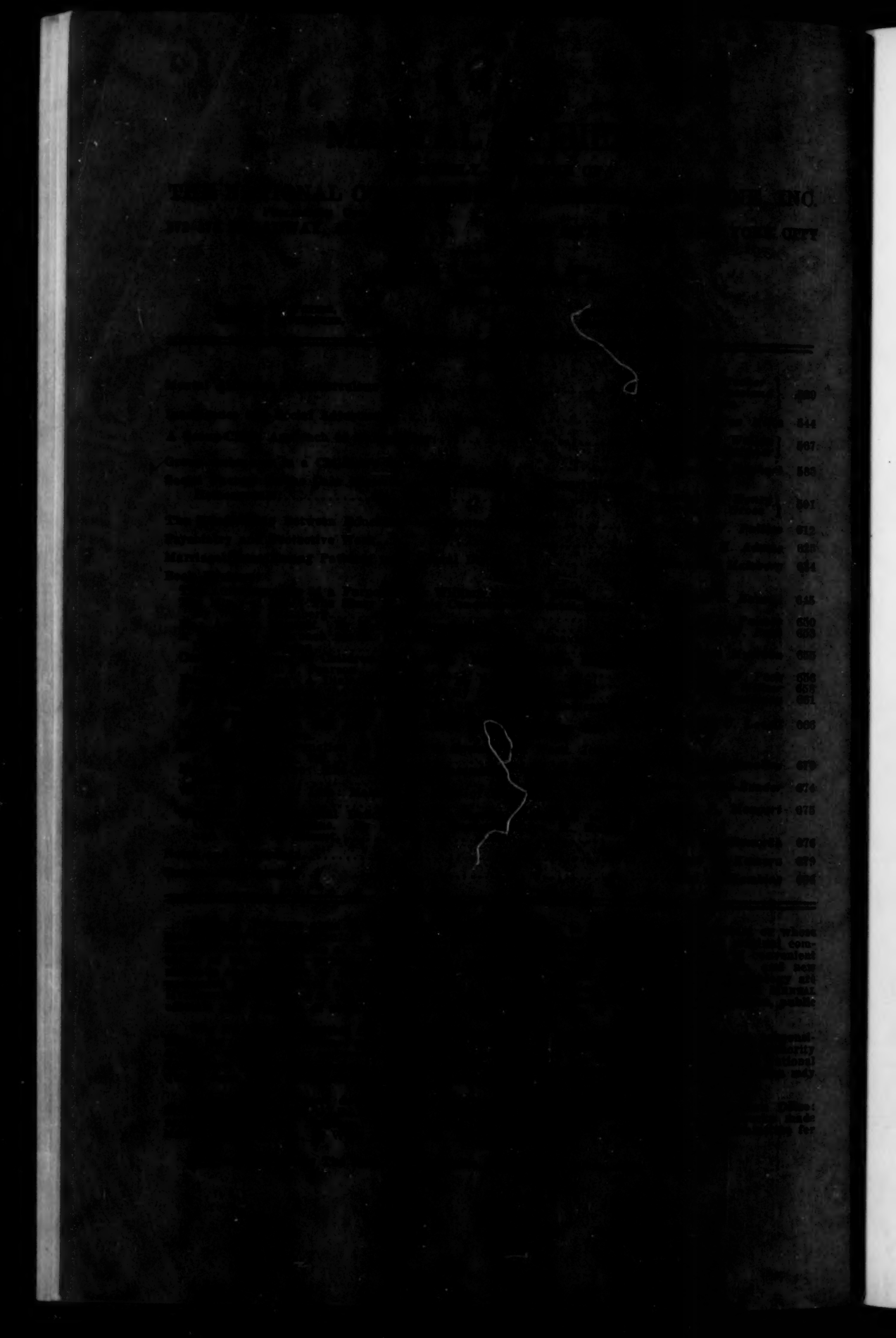

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MENTAL HYGIENE aims to bring dependable information to every one whose interest or whose work brings him into contact with mental problems. Writers of authority present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public are republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology are presented and discussed in as non-technical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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# ORIGINAL CONTRIBUTIONS

MENTAL HYGIENE

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# MENTAL ATTITUDES OF TUBERCULOUS PATIENTS

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THE need of considering the mental attitudes of patients with chronic disease is obvious. As Dr. Henry A. Christian has pointed out, "practitioners of medicine are finding out more and more how important a part is played by the mind and its aberrations." Mental attitudes are particularly significant in cases of pulmonary tuberculosis because such patients are often disturbed by the fears and prejudices of those who have wrong conceptions of the disease. Experience with more than two thousand cases shows that long periods of sanitarium care, with more or less prolonged isolation from family and friends, may influence unfavorably the course of the disease, unless there is a clear and thoughtful understanding of the patient's social and mental state. Without some adjustment, the patient may even leave the sanitarium before cure has been established, and go from place to place, spreading infection and doing himself untold harm. Thus tuberculosis claims our special attention not only from the point of view of treatment, but as an important public-health problem.

Pulmonary tuberculosis takes its toll in high and low places. Among its victims were Cicero, Milton, Pope, Keats, Shelley, Goethe, Schiller, Molière, Kant, Spinoza, Mozart, Chopin,

Balzac, Samuel Johnson, Stevenson, Voltaire, Rousseau, and Irving. It has also scourged the poor and lowly. Its wide diffusion is only one of the many claims it makes for psychiatric investigation.

The present investigation was started in 1935, with the aim of determining the mental attitudes of tuberculous patients undergoing sanitarium and home treatment. We were particularly interested in studying the euphoria, or sense of well-being, which has a textbook reputation as one of the compensations of tuberculous patients. An attempt was made to determine the percentage of patients who were consistently euphoric and the setting in which the euphoria appeared. Naturally we scrutinized the personalities in the pre-tuberculous stage and tried to determine whether or not the pulmonic invasion and its concomitants had changed essential personality patterns. While we were engaged in the study, the late Dr. Thomas McCrae suggested that we investigate also the truth of the common belief that in tuberculosis sexual desire is increased.

Several types of institution were visited by a psychiatrist, ranging from the tuberculosis wards of city hospitals to small private sanitariums in rural districts. The patients were selected at random, all economic, social, and cultural levels being included. We hoped in this manner to cut an authentic cross section. The little monthly papers published in some sanitariums were examined and the available "literary output" of patients was studied. One senior medical student made a valuable contribution by placing at our disposal the diary and memoirs of his stay in a small tuberculosis hospital. The patients were questioned at length after having been allowed to tell their own stories. No notes were in evidence and the protection of anonymity was promised.

*Previous Personality and Reaction to Illness.*—Of the seventy-five patients who are discussed at length in this paper, thirty-one had been preponderantly of the introverted type and thirty-seven had been mainly extraverts before the onset of the tuberculosis. In seven of the patients outgoing and ingrowing tendencies had been fairly well balanced. Sixty-four were passing through the illness without marked changes of personality. The other eleven had changed somewhat, and

indices of the change are illustrated by remarks like these: "I have become more sociable. I was formerly quite shy. Living in community life has enabled me to know people better and to understand them." "I am not as friendly or as trusting as I was. I feel so alone that I prefer my own company. My friends have deserted me. I am much quieter than I used to be and a hundred times more bitter."

The reactions of the patients upon learning that they had tuberculosis were interesting and diverse. Some of them had previously had no idea of the illness or its manifestations; others had conceived their opinions of it in ignorance and fear. An example of this latter type was a young girl born of foreign parents who said that the only time she had ever heard of tuberculosis was once when her father announced to the family that he would rather bury all of his children than have them ill with "consumption." Naturally, she believed that tuberculosis must be both a physical and a moral catastrophe. One can well imagine the state of her emotions when, ten years later, she was informed that she had pulmonary tuberculosis. Of the group in question, forty-one had been frankly informed by physicians as to the nature of their illness. A few had suggested to physicians that they might have phthisis because their symptoms were similar to those of some relative or friend who was a known case. Six patients said that they had "half suspected" the nature of their illness and had not been surprised when the diagnosis was made. The remaining patients had been quickly enlightened by others upon entering the hospital.

In addition there was a wide variety of other reactions, ranging from religious acceptance of the illness as God's Will to contemplation of suicide and plans for carrying it out. One of the most interesting reactions came from a rather brilliant girl, a senior in a Western college. She said: "I had been feeling very badly for a year. I was difficult and nasty to people. It was really a relief to be told that I had tuberculosis. I was elated to think that I could 'give up' and have things done for me. It was even a relief to give up friends and family and to go away, because it had been so difficult to carry on. Then suddenly I got the things that I had always loved. I was sent to a beautiful place and could see lovely

mountain scenery from my window. I had music and books and all day to enjoy them. It was very pleasant, but beneath it all was a feeling of depression." Another girl also found tuberculosis a relief because she had been contemplating suicide. She was having marital difficulties and had no idea as to how she was going to solve her problems. Tuberculosis furnished the means of escape, and she was content. In many cases the reaction was mild because of tactful handling by physicians. Three of the patients became profoundly depressed and several others tried suicide. Some continued to carry on their daily tasks and refused to stop work.

Many of the patients noticed irritability as the first manifestation of their difficulty. Carncross, quoting Dr. D. J. McCarthy, points out that the spinal reflexes are very frequently increased in tuberculosis and concludes that this irritability is also present in the brain. He calls it the "irritability of weakness." / Some of the group under study were being treated for "nervous breakdown" when the real cause of their trouble was discovered. A number of them felt sure that the various marital, physical, and economic stresses under which they were laboring were the causes of the disease. One intelligent man, the vice-president of a manufacturing concern, said that his mother and father had both had tuberculosis and both had lived to be well over seventy years of age. He was convinced that if he had not been battered by an economic crisis, he would have been able to go through life with tuberculosis, but without breaking. The causes of stress were many. One seventeen-year-old girl became ill after a "nervous breakdown" for which she had to spend the greater part of a year in bed. It sounded suspiciously like hysteria and was brought on by the fact that her parents were going to import a foreign husband for her. He was an older man, an unknown quantity, and she decidedly did not want him. Needless to say tuberculosis was not entirely unwelcome in her case.

In some instances, the illness was merely the culmination of a long series of unfortunate happenings. Witness the following train of misfortunes that followed a young male patient, aged thirty. Two years after he married, his bank failed and he lost all of his savings. His wife's sister died and he had to borrow the money to bury her. His business failed, his wife

was taken ill with tuberculosis, and he lost the sight of one eye in an accident. His wife became progressively worse and died after giving birth to a baby. To cap the climax, he himself was stricken with tuberculosis. One can well imagine his mental state. The above examples are extreme and the majority of patients were not under severe strain at the time when their lesion was discovered.

*Affect and Mood of Tuberculosis Patients.*—The moods of the seventy-five cases discussed here may be classified under the following headings:

| | |
|---|---|
| 1. Fatalistic, "making the best of it" | 35 |
| 2. Depressed | 29 |
| 3. Marked mood swings | 4 |
| 4. Happy (euphoric)? | 7 |

In the evaluation of mood, the influence of economic factors seemed impressive. It was largely expressed in terms of security and insecurity feelings. One patient, H. M., an intelligent girl twenty-three years old, stated, "I would be content to stay in the hospital and 'cure' no matter how long it took if I knew that my bills would be paid or that the state would take care of me. It is the constant fear that I do not know where the money is coming from that holds me back." E. W., female, aged twenty-five, said: "The patients who are worried about finances do not do at all well. My board is paid by my county and my mother cares for my baby. If it were not for these factors, I would not want to get well at all." One man, aged thirty-four, said that he could content himself if it were not for conditions at home. With the present situation, he was bitter against the world in general and social workers in particular. A train conductor announced that he was quite happy and felt fine because his company continued to pay his salary. Two weeks later it stopped, and then he lost his contentment and refused to stay in the hospital. It might be argued that no matter what the illness, the patient is influenced by his economic condition, but in tuberculosis the effects are especially important because of the chronicity of the disease.

Among the twenty-nine "depressed" patients, there were all gradations, including suicidal tendencies. One girl insisted that she was quite happy, but she wept throughout the

interview. She said that she cried daily, as do many other patients. One girl of seventeen years who had been in the hospital only forty-eight hours and who did not know who we were, remarked: "At first sight you think these people are happy, but when you catch them off guard, they are sad and weepy." Two patients of this group had attempted suicide.

Patients who were characterized as "fatalistic" usually remarked that they were "making the best of it," adding quickly the question, "What else can one do?" Their reactions were varied. One said: "I tried rebelling against this disease for six months and slipped backward steadily." Others asked: "How can one be content away from one's family and friends?" "How can one be happy when he has a chronic disease from which he might not get well?" "What happiness can one get from lying constantly in bed looking at the ceiling? The thing to do is to 'kid' yourself—to 'fix it up with yourself.'" "See how anxious the men are to read. They do that so they do not think of themselves and despair." One very intelligent man remarked: "We are superficially happy. What else can we do? Beneath it all we are depressed. We are a people apart, and the sword of Damocles hangs over us. We joke about the undertaker coming for us, but it is really distressing."

An undercurrent of bitterness and frustration ran through these replies. There was an anger which was ill concealed. Several of the patients remarked: "Why must I contract such a terrible disease? I am envious of my friends and family. They are well. I almost hate them for it."

Seven of the patients were indicated to us as real examples of euphoria, and patients, physicians, and nurses assured us that they were genuinely happy. A short résumé of these patients follows:

*Case 1.*—Female, aged twenty, student. This patient felt that her happiness was deep. She was elated most of the time, she remarked—almost too much so. She said, "We laugh at the silliest things here, almost hysterically. I stopped thinking when I came up here. I don't dare to think because I know this is going to interfere with my future." Later examinations cast a doubt on the presence of tuberculosis in this patient. The sputum showed only one bacillus in ten examinations.

*Case 2.*—Male, aged thirty-four, conductor. This man was obsessed by an idea of the great curative value of onions. He had read about this in the newspapers. He attributed his feeling of well-being to onions,

and when he was deprived of them, he became a very different patient. He was definitely a moron; his I.Q. was low, and his euphoria was open to question.

*Case 3.*—Male, aged thirty-nine, railway employee. This patient said that he was quite happy. He was noted for his cheerfulness. He was the person cited previously who said that he was not worried because the company was paying his salary. His salary was stopped and he left the hospital the same day. He also confided that he was anxious to return home because he was suspicious of his wife's conduct with a boarder.

*Case 4.*—Female, aged thirty, a nun. This patient was obviously happy and contented. She was recovering from a serious illness and had no pain. She said, "I am happy. I accept this illness as God's Will. I will either get well or die, but I accept it."

*Case 5.*—Female, aged twenty-nine, clerk. This woman had been quite depressed, but when she found that she was not going to die, she squared her shoulders and was determined to get well. Now, she said, she felt "very good," hastily adding, "almost too good."

*Case 6.*—Male, aged thirty, mechanic. This patient felt elated. His father was looking after his affairs while he was ill. His history showed that before the onset of his illness he had had two "nervous breakdowns" and periods of depression, followed by periods of elation. He had felt elated for only two weeks. Before that he had been so nasty and irritable that it was difficult to live with him. He said, "I was so nasty that if any one made a noise with my dishes, I would not eat my meals."

*Case 7.*—Male, aged seventeen, hat cleaner. This boy believed that he was genuinely happy. He knew little about life outside of a hospital, having been in tuberculosis sanitariums since the age of ten. He was now faced with an operation (thoracoplasty). He said that he realized he might not recover, but "What else is there to do? I might just as well die that way as any other."

This cross-section study of the patients who were said to be euphoric was not very convincing. In no instance could it be said that there was a definite euphoria which was a product of or an accompaniment of tuberculosis *per se*. The first patient may not have had tuberculosis and her reaction throughout was one of compensation for a career which she felt was blighted. Patient No. 2 was a moron, and his opinion was of no great value. He attributed his feeling of well-being to onions. In Case No. 3, the patient did not have a very good grasp of the situation and regarded his sojourn in the hospital as a vacation with pay. When the pay stopped, he left the hospital. Patient No. 4 was a religious who would have accepted any illness with the same resignation. Patients No. 5 and No. 6 were definitely of manic-depressive make-up, and we

no doubt saw them in an upswing. Had they been examined earlier, we might have classified them as depressed patients. Later observation proved that their euphoria was not constant. The last patient mentioned knew little else but sanitarium life, and his reaction was partly a form of compensation for the fear that he felt over the approaching operation.

In the group of moribund patients there were some who were making plans for the future and who seemed to be euphoric, but this was more evident at the beginning of the examination than later. Evidently the symptoms were so beclouded by toxic delirium that they were rendered valueless for our study. It is noteworthy that in the large series of patients studied there were no cases of euphoria that were not tainted. None of them could be regarded as being euphoric as a result of the presence of tuberculosis.

When a chief-of-service is making rounds on a ward, he is apt to gain a false impression of the true mental state of the patients. The ward is "on parade," as it were. He is usually accompanied by a retinue of nurses and residents, and the presence of the group camouflages the atmosphere. We made rounds with such groups and then again immediately after the group had left the ward, and we found the tenor vastly changed.

*Thoughts and Phantasy Life of Patients.*—Obviously the patients had much time on their hands, yet we found only thirteen who admitted excessive daydreaming. In none of the patients was the phantasy very deep or complicated; it seemed to be on the basis of a rather simple compensatory pattern. It did not resemble in any way the phantasy of the schizophrenic patient. The daydreaming was not wholly planless, often involving plans for the future either for the patient or for the patient's children. One girl said that she was an incurable daydreamer and was awaiting a knight on horseback, but then she was only nineteen years old and an extravert. It was not an abnormal reaction. Several of the patients said that they built castles and made their plans and then suddenly realized that they might not get well to carry them out. This was depressing and they daydreamed with reservation—as one girl aptly put it, "with her tongue in her cheek"—because of the realization that the plan would have to be changed. Another patient observed, "Yes, I constantly

daydream, and the dreams are not even sensible, they are so remote." In general, the patients showed a fatalism that was distressing. Some of their remarks are as follows: "What is the use? We are here to-day and gone to-morrow." "No use in our making plans. They won't come true anyhow. There is so much that can go wrong." "We probably won't even get well. Nothing ever turns out right." "I even get cross and bitter when I read stories in which people live happily ever after." "Build castles? What for? I never had anything and never will."

Remarks of this type are not indicative of contentment or happiness. And they are not isolated statements from a few patients, but on the contrary are typical answers from patients of all classes in different types of institution.

The writings of patients also give an insight into their trends of thought. The following gems are quoted from articles contributed by patients to their sanitarium papers:

"Bugs to the right of us,
Bugs to the left of us,
Bugs inside of us,
Gnawing and chewing."

The following quotation was the second stanza of a lugubrious poem entitled *Life:*

"The path we've found is hard and bare 'tween
A roadside ugly and unkept. With broken
Limbs we hobble on, still seeking, ever
Seeking realms more sweet beyond. For none
There be who knows what over yon hill lies."

The next quotation was abstracted from a poem written by a man who was having difficulty with his wife, and who felt that he was neglected and misunderstood. Psychologically it is revealing.

I

"On most days, I 'm really tough,
Tough as tough can be.
I want no one to care for me
I'm big and strong you see.

* * *

V

"But if I must get married
Perhaps some time or other,
I'll only take the one I want,
I'll only marry mother."

Many of the short contributions were sad and funereal; they certainly did not contribute to the gaiety of the patients in the institution or lend support to the belief that tuberculosis softens its sufferings by a protective cloak of emotional euphoria.

Perhaps the most persistent and consistent note in the emotional scale of tuberculosis was apprehensive anxiety. Its manifestations were protean, concerning the future of the patient or his family, the economic status, the outcome of the disease, and many other features. Many patients were fearful of their reception by families and friends after their return from the hospital. Each patient knew one or two stories of the cold reception accorded to some one whose disease process had been arrested. For the most part the stories conformed to type and the following are examples: "Just as he was about to go home, he received a telegram from his brother telling him not to stop in on his way home, as they were afraid for the children." "The day upon which she was to be discharged, her sister wrote her offering to pay her board somewhere else, but telling her not to come home." These stories distress the patients and are kept in mind. They serve to further the idea that tuberculous patients are a people apart. One of the patients, a young economics teacher in a university, remarked that he would leave the hospital within the next week and would immediately go West, not stopping to see his friends, even though he wanted to visit them very much. He said, "I would like to have dinner with some of them, but I fear that they would be careful with the dishes I had used and I could not stand that." Another man who was socially prominent said: "I could never go home again. My wife comes to see me and does not even shake hands with me. My aunt stopped coming to our house when she heard I had t.b." Another person remarked: "Just now I hate society and wonder if it will shun me when I get out." A Jewish boy said: "If you have t.b. people will shun you. They do not know what they are afraid of, but they are afraid. I have lost my dearest friends. Even my adopted brother has dropped me, and we were very close during childhood." One attractive girl who had studied nursing and was an "arrested case" felt that she could not go back to her home town again as people

would be apt to avoid her. She said: "That would kill me." Some of the patients kept their whereabouts secret and did not intend to tell any one of their illness. Some intended to start anew in another locality. Several patients bewailed the fact that there was not some place to which recovered patients might emigrate, since there no one would slight them or ask questions. One patient said: "Even prostitutes avoid a man suspected of tuberculosis." These fears might be termed "social fears" because they were concerned with social matters rather than disease processes.

*Malingering.*—Following naturally in the wake of fear and insecurity were instances of malingering. This was particularly noteworthy in patients who were being supported by the county. A return to health meant a return to one's family and, inevitably, seeking employment and entering into competition with one's fellow men. In the sanitarium all things were done for the patient. He was waited upon and given medical attention, and nothing was expected of him. Naturally some of the patients were reluctant to leave these surroundings and return to poverty-stricken homes, particularly since they anticipated a measure of social ostracism. The following malingering devices were brought to our attention:

1. A patient may elevate the thermometer reading by means of wrapping a dry cloth on the bulb and blowing hard upon it, or by touching the thermometer to hot-water bottles or to nearby radiators. This is possible when the nurse does not remain at the bedside.

2. One patient would develop coryza every time the doctor spoke of his going home. This was accomplished by going to the bathroom in his bare feet. It served to delay departure, lest perhaps something serious should happen.

3. Some patients were able to make their gums bleed, thus causing "streaking." If this was called to the nurse's attention, she would report it to the physician. Other patients achieved the same objective by mixing chocolate in the sputum.

4. A patient with a negative sputum may change it for that of some one known to be positive. One girl who was "negative" was applying for admission to an institution in which a positive sputum was demanded for admission. She laughed knowingly and said that she "could fix that."

*Observations on the Sexual Question in Tuberculosis.*—It is commonly believed that patients who are tuberculous have increased sexual desire. The patients themselves are aware of this belief. Frequently when the subject was broached, the patients would say: "Do you know, Doctor, we discussed that subject several days ago?" They would then add their own conclusions. For the most part they were freely communicative, and we felt that only three of the many patients questioned were not frank in their replies. Of the group of seventy-five patients with whom the subject was discussed in detail, there were only four, three men and one woman, who felt that desire was increased. One clergyman, a chronic patient, made the following pertinent statement: "If there is increased sexual desire among the patients here, it is not because of tuberculosis. It is because there are many married people away from home, who feel well, eat a highly nutritious diet, and lie around all day. If people from a wealthy community get into sexual difficulties, we are prone to blame it on the fact that they have too much money and too much time on their hands."

By far the largest group of patients said that for them sexual desire was the same as before the onset of illness or even somewhat lessened. Some called attention to the fact that they felt badly physically and that any sexual urge which they might experience was greatly overshadowed by their interest in getting well. About one-fifth of the group claimed to have little or no knowledge of the subject. It was reasonable to believe that this was true, as this group contained unmarried women, adolescents, and those in religious vocations.

Examination of the four patients who felt desire to be increased brought to light some interesting facts. As mentioned before, three of these patients were male and one was female. Two of the men in question were of foreign extraction. They had been sexually hyperactive since boyhood. One of the young men had all of the ardor that one would expect to find in an eighteen-year-old adolescent who was being made to lead an inactive life after a period in which he had "run wild." The other man, a moron, had for years prior to the onset of his illness consorted with prostitutes. During his stay in the

hospital, he kept his desire at fever heat by reading numerous "art" and pornographic magazines. We could not conclude that in their cases increased sexual desire was conditioned by tuberculosis. The third man felt in a vague way that his desire was increased because he constantly phantasied about the future, and it was always understood that it would be spent with a wife or mistresses. He was having marital difficulty at the time of his illness and dissolution of his marriage was imminent. He attributed his increased sexual desire to sheer loneliness and wish for companionship. The female patient was positive that her sexual desire had increased markedly. When questioned carefully, she decided that it was due to her illness. She said that she, like all other tuberculous patients, realized that she had not long to live and wanted to concentrate her pleasures. Here was a definite statement by an intelligent woman who gave a plausible reason for her feelings. This single instance of seemingly increased sexual desire was discounted by the fact that three weeks after making the above statement she was sent home from the sanitarium because it was decided that she did not have tuberculosis!

*Influence of Surroundings on Patients.*—Many tuberculous patients are profoundly affected by their surroundings. The decorations, the appearance of the wards and rooms, their fellow patients, are all influences that aid or disturb their tranquillity. That these influences are important is well known to the medical and nursing staff. The administrators of one chest hospital in which we worked resorted to the expedient of painting the walls and furniture with bright colors. The patients insisted that it helped "brighten up" the place in general. This hospital also rented pictures from an art alliance. These methods of diversion were quite successful, and brought about a psychological optimism in several difficult patients. One man in particular who was a "problem child" was helped considerably. He had been a thorn in the side of the medical and nursing groups. Several times the administrator had considered sending him home. He was encouraged to take part in the classes and as a result his energy was directed into harmless and useful channels. In an institution that neglected such helpful adjuncts, there was much poorer morale. One man remarked that he was "nearly

driven crazy by the hard, flat white walls." Several patients compared these whitened walls with "whited sepulchres."

Another factor that contributed to morale was the classifying of patients so that those of nearly the same intellectual level were kept together or made roommates. One patient said: "For a while I was in a cottage which was full of very sick people, yet the doctors told me I was an early case. It was not very reassuring. Then, too, I had a roommate with whom I had nothing in common. I feel better now. My roommate is a man with whom I can occasionally carry on a conversation."

The patients themselves were aware of the fact that the proper mental attitude is a factor in recovery. In answer to the question, "What is the most important factor in getting well from this disease?" two-thirds of the patients answered, "Peace of mind." Many of them were able to quote instances that would bear out this statement. One patient said: "If you are worried or fretting, your rest and appetite suffer and you lose ground. I am sure of this because I fretted for six months and steadily got worse. No one knew what was the matter with me."

A great many patients were able to content themselves all day, but dreaded the coming of night. "Nights are so long." "The evening hours drag. There is no visiting, and many of us start to think of our homes and our friends." This was responsible for tears on the female wards and increased irritation or depression on the male side.

A distressing influence which is noticed in all tuberculosis hospitals is the tendency of the patients to talk about their illness. In many places it appears to be the sole topic of conversation. This is felt keenly by new patients. The knowledge the patients have of their own pathology is startling. One woman remarked that her lesion was spreading and that her left lung was now involved. When asked how she knew this, she answered that she had seen it marked out in the diagram on her chart. She added that all patients watched the doctor as he studied the chart and often they could catch a glimpse of it. The net result of her recently acquired knowledge was a period of deep depression. Any knowledge gained seems to spread at once throughout the hospital by a form of "grapevine" which defies description.

## CONCLUSIONS

As a result of the observation of approximately two thousand tuberculous patients from a psychological angle, and the complete study of seventy-five patients, we offer the following conclusions:

1. We were unable to find that euphoria is an accompaniment of pulmonary tuberculosis *per se*. On the contrary, we found that depression and fatalism, anxiety, and apprehension constituted the prevailing moods. In those patients who were superficially elated, adequate cause other than the disease could be found.

2. We were unable to substantiate the belief that tuberculosis is accompanied by increased sexual desire. In most of the patients, this desire remained the same as before the onset of the disease or was lessened. In those patients who claimed increased desire, other causes were demonstrated.

3. The psychological and psychiatric angle of the patient is an extremely important one and in most hospitals it is entirely neglected.

4. Attempts to brighten up the institutions, to occupy the patients' minds, and to make them feel more secure will improve morale and facilitate recovery.

5. Extreme care should be used in advising patients of the extent and nature of their disease.

# INTELLIGENCE AND SOCIAL ADJUSTMENT*

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"GENERAL intelligence" and "general mental ability"—in early English writings designated as "wit," more recently and familiarly as "brightness," "cleverness," or "brains"—were recognized as significant facts long before psychologists undertook to measure or to define them. And to-day, whether or not we have precise indices of achievement or performance to prove it, we know and act upon the knowledge that samples of intelligent or insightful behavior generally indicate a dependable expectation in terms of other samples or of performance in school, shop, or marketplace. In social life friendships are sought, in schools promotions are made and recommendations to higher institutions are given, in business and industry applicants are selected and employees are appointed, on the basis of this knowledge.

The modern science of mental measurement has proved this universal assumption by demonstrating a positive intercorrelation among various mental-test scores, and statistical agreement between these and other measures of recognized achievement. There is, perhaps, a positive correlation of all good traits; at any rate, we are now justified in assuming that an individual who does one kind of mental work in a superior way will generally succeed beyond the average in other kinds. The examples sometimes cited to disprove this widely accepted view are isolated in comparison with the multitude of individual cases and the mass of statistics that support it. Tests of intelligence requiring one or two hours' work have been devised, and are now generally available, by which it is possible to predict degrees of success in performance in specific types of mental activity or along any of the

* From a series of lectures on the Social Aspects of Psychiatry, arranged by the Department of Psychiatry and Mental Hygiene, Yale University School of Medicine.

more desirable lines of human endeavor. Such predictions in individual cases are of course fallible, but they are certain enough to serve as useful guides to economical practice, whether in education or in industry. To the question, "What is intelligence?" common experience answers that intelligence is something of individual and social importance about the mind, which is revealed in everyday doings, which can be practically measured, and the measures of which prove useful as data in many lines of human engineering. From this conclusion, based on observation accessible to every one, we may proceed to examine intelligence as viewed by those who have devoted their special attention to its definition and measurement.

Intelligence is now generally thought of by psychologists, in agreement with the common-sense view, as a trait expressed by living beings through their actions. It is not regarded as a substance or quality that exists independent of action. Individuals are observed to display in their behavior a certain greater or less degree of intelligence, and this behavior quality is more or less characteristic of the same individual at different times. Biologically intelligent behavior is thought of as involving the sensing by the organism of stimulus changes in its environment, together with the subsequent adaptation or adjustment appropriate for survival. Thus the more intelligent organisms tend to be those that persist in the evolutionary process. In the treacherous tar lakes of California are buried the bare bones of hundreds of stupid saber-toothed tigers, a species now extinct, together with the remains of a few elephants. The majority of the ruminants, with their noteworthy mental astuteness, avoided the tar trap, and they continue to roam the earth long after the tigers fell victims to their own stupidity.

Early definitions of human intelligence recognize its evolutionary significance. Thus Stern emphasizes as a primary aspect the "general mental adaptability to new problems and conditions of life." Furthermore, this ingenious investigator points out that intelligence is not talent or the development of a specific ability, not mere information or knowledge, and not memory, which deals only with the past. Behavior, he said, is intelligent "just in so far as it includes a new adjust-

ment to new demands." It is obvious that intelligence in this emergent sense requires a highly developed and smoothly functioning nervous system, one that permits of a great variety of possible responses and that is capable of a great number of effectively patterned reorganizations and readjustments. It is thus typically characteristic of man among the living organisms.

Educationally, intelligence involves and implies the ability to learn, which is in fact a special aspect of developmental adjustment. The very intelligent are those who learn easily and well. The unintelligent learn only with difficulty and find the process of learning relatively hard and unenjoyable. Adjustment, readjustment, learning, all involve the capacity of the organism to react or behave in appropriate terms. This capacity or ability which makes intelligent behavior possible, and which we may posit as inherent in the organic constitution, was especially recognized by Binet, the father of mental testing, in his definition of intelligence as judgment or common sense, and by his lineal psychological descendant, Terman, when he wrote, "an individual is intelligent in proportion as he is able to carry on abstract thinking."

The statements of these two creators of our most useful measuring techniques have been amplified by other formulations. Pintner reminds us that intelligence is "the evaluation of the efficiency of a reaction or group of reactions under specific circumstances," and Thorndike has added a descriptive analysis of its attributes: altitude, range, area, and speed. Goodenough points out that "we act most intelligently when we respond to relationships between things, to abstract ideas and general principles," and, further, that "intelligent action is planned action, action that is determined by the organization of many simple meanings into a complex and relatively complete whole." It is effective action that achieves a result. Piéron states: "Intelligence does not exist in the mental mechanism; it is only an effect, a functional resultant under certain defined conditions, a behavior value."

Intelligence may, then, be conceived as a resultant at the behavior level of the expression of a given constitution, with its unique experience, reacting under the special conditions

of its past and present environment. It is biologically conditioned, educationally and culturally developed and analysed; and to the extent that the organism is potentially capable and habitually stimulable, it is expressed typically in every self-directed action. To the integration of the organism we may attribute the observed similarity of quality in the action series of a given individual, and through this we see emerge a characteristic intelligence pattern. Samples of intelligent acts are recognized as typical by those associated with the individual, and when measured, they serve as indices of the quality of his behavior, and as predictors of his reactions under other sets of conditions. Intelligence is viewed as a quality of higher organic adjustment, observable and measurable through the many series of life acts in which the adaptive element is crucial. It is recognized as of greater or less degree according as it is planful and effective in the reduction of trial and error and in the development of new and more adequate patterns of life behavior.

*Development of Tests of Intelligence.*—It was the concrete need on the part of physicians to diagnose in some objective way oligophrenia or commitable feeblemindedness that stimulated the early development of tests of intelligence. The instruments of measurement evolved in response to the need presented by this diagnostic problem proved effective, under competent control, to differentiate those most apt to require institutional care by reason of inadequacy of mental function. At the same time the measurements brought to psychological and medical attention the additional possibility of classifying with approximately equal efficiency the great mass of persons of average intellect and also the smaller groups of the exceptionally well endowed.

The measures sought were practical ones, in the first instance crudely so, but the information regarding the development and distribution of human endowment brought into view by them and their somewhat more effectively refined later forms have contributed fundamental principles to modern education, have aided industry in its effort to fit the job to the man as well as the man to the job, and have contributed valuable techniques and norms which may enter usefully into social and medical studies and especially into the psycholog-

ical or psychiatric studies of personality and experience, in approaching which these two important points of view are becoming fused.

*Intelligence, a Unique Index of Achievement.*—Intelligence seems to be unique as a relatively measurable correlate of human achievement. There is no comprehensive physical measure that serves at present in a similar way. Body size, for example, has a certain relationship to achievement and specifically to achievement in certain occupations or professions, but there is no such direct relationship between stature and any index of economic or occupational achievement as holds for intelligence. It is probable that the work of piano-movers or members of a police force requires a certain size and height, but there are other types of activity perhaps equally well regarded and equally important in which small stature and small size are adequate or indeed essentially desirable. Jockeys and coxswains play important parts in their respective activities, and detectives and secret-service men, whose duties are as important as those of traffic captains and peace officers, are not selected by the criterion of great size.

Muscular strength and physical energy, endocrine or metabolic measures, chemical or electrical potentials, cardiac or respiration indices furnish at present, singly or combined, no such criteria of graded capacity for human achievement as does the test index of intelligence. Nor is there any emotional measure or index as yet available to indicate as does the intellectual criterion the fields of achievement in which success is most probable or most possible, whether for individuals or for groups.

*Phases of Social Adjustment Involving Intelligence.*—The social adjustments into which intelligence enters significantly are those involved in the group life, activities, interests, and achievements, both social and occupational, and in the individual or personal adjustment of the individual ego or self within the cultural structure. Intelligence we may thus conceive of as an element that enters in to determine the group or class to which the individual may or should belong, regardless of his social background, because in it he may hope for comfortable and successful living for himself and thus also for his

associates. It is also an element that determines in no small degree the place of the individual within this group or class, whether as leader or follower, in the upper or the lower ranks of achievement as the world or *his* world measures it. In both of these classificatory placements, in whatever social hierarchies they may occur, adjustments to one group or more are involved. Intelligence may also be an element in the self-adjustment that develops and crystallizes within group limitations, in self-appraisal, self-direction, and self-modification along patterns conceived of as personally or socially desirable.

It is obvious that intelligence, as defined, must play no small part in the trial-and-error progressions of any person into a more or less appropriate and comfortable individual and social groove or niche. The range of intelligence involved in these adjustments is wide. At its lower limit in age terms are infants whose intelligence has yet to grow and develop through life experience; at its upper limit of age growth are young adults entering upon mature life. In terms of capacity, its lower extreme is represented by the defective organism that never emerges from mental infancy; at its upper limit are the intellectual giants of industry and the world of affairs, of art, literature, science, and philosophy.

A few sample relationships between intelligence and social adjustment may serve to illustrate the kinds of demonstrated interaction that prevail in our society. We need not linger to bring proof that there is a high correlation between intelligence and cultural age in infancy, childhood, and youth. As life age increases from birth onward, so also does measurable intelligence grow and with it the capacity of the individual to meet effectively the demands of his environment. This correlation between intelligence, growth, and adjustment potential holds for the weakest as for the strongest intellect.

*Intelligence and Educational Adjustment.*—During the period of growth, which involves both the physical and the mental elements of the organism, the educational sorting process takes place in terms largely correlated with intelligent behavior. The rate of school progress, the achievement in school subjects, and the educational level finally reached are all correlates of intelligence. Thousands of studies attest these relationships. The size of the correlation index depends

upon the size of the group studied, its heterogeneity or homogeneity, the accuracy of the measures used, and the coöperation elicited from the pupils. In summary, it may be said that among school children, less than 5 per cent are feebleminded, 15 per cent are dull, 60 per cent are average, 15 per cent above average, and 5 per cent are superior, and these categories determine the approximate rate and the limits of school experience. Feebleminded children generally repeat many grades and do not usually go beyond the fifth. Their poor school work is usually noticed from the first grade onward. Dull children generally repeat one or two grades and do not usually go beyond the eighth. Their poor work is generally noticed in the fourth or the fifth grade if not before. Average children generally go through the grades at par and usually continue to the second year of high school. Their work is generally adequate up to the last years. Above-average children sometimes skip one grade and usually complete the high-school curriculum. They may also attend college for a year or more. Their work is generally somewhat better than that of their school associates until they reach the college level. Superior children commonly skip one or more grades in the public school. They finish the high-school course and usually a college training also; their work tends to be outstanding.

The relationship between intelligence and educational adjustment has now fortunately become in most communities a basic assumption, perhaps even a commonplace. But progressive educators in the most adequately staffed school systems recognize that the goal of successful approximation of personal potential and stimulating opportunity is still a distant objective. And they are activated to further constructive effort by the consideration that the many elements other than the intellectual that enter into the complex personalty-adjustment equation are only beginning to be understood.

*Intelligence and Economic Adjustment.*—There is no index of economic success that does not show a positive correlation with intelligence if a sufficiently representative population sampling is considered. The intelligence quotients of public-school children grouped by Hildreth in terms of economic level (Taussig's scale) illustrate the persistent involvement of the

intelligence factor. For the category of "unskilled occupations," the I.Q. average of the children is 76; for the semi-skilled, 84; for the skilled, 98; for business, executive, and semi-professional occupations, 108; for the higher administrative business and professional pursuits, 113. Evidence that these differences are not attributable primarily to environmental factors comes from elementary schools, where the children show intelligence-score differentiations in terms of fathers' occupation similar to those of pupils in the upper grades and high school. Even pre-school children, when grouped in terms of the family economic status, show the same hierarchy in terms of intelligence scores. This is the more noteworthy because the simple tasks that make up the lower levels of the intelligence scales—such as pointing to the eyes or the mouth, copying a square or a circle, counting four pennies, pointing out objects in pictures of familiar scenes, obeying simple commands—would seem to be equally available as experience in homes of little or of much culture. Community and racial differences probably color statistics for older children. City and country cultures no doubt influence test scores partly in terms of educational opportunity. Private-school children and those from superior homes have obvious advantages not available to tenement children or orphans. But the presence of the same hierarchical tendency in children who have never been to school, when measured in terms of simple motor and verbal acts practiced by every one, gives convincing force to the total correlational array.

*Intelligence and Occupational Choice.*—The expressed occupational choices of children are largely influenced by educational opportunity and cultural background. But the occupational adjustments made by these same children, and by their parents and older siblings before them, tend to follow the intelligence hierarchies. To the great mass of data secured from the army studies, a steady stream of further material has been added, confirming the earlier results. From these the persistent relation between intelligence, education, and occupation emerges as a definite datum of our present culture.

Repeated occupational samples define the categories. As

much below the grade-school level as that mean is below the high-school are the occupations of laborer, miner, and teamster. At the grade-school-trained level, are such trades as those of butcher, baker, plumber, carpenter, and mechanic. At the level of high-school training, we find stockkeeper, construction foreman, telegrapher, photographer, the non-college-trained nurse, and the principal clerical occupations. At the college level, are accountants, mechanical draftsmen, dentists, and the majority of business employers. Above the college levels, are the professions, law, medicine, engineering, and others requiring post-collegiate training of intellectual type.

The wishful choices of school children and young adults which fail to take ability into account are of interest and importance to psychologists and social workers, indicating as they do an unavoidable social-value stress inherent in present-day social attitudes. Adequate outlets in recreational and artistic pursuits may help to solve the difficult problem of wishful occupational thinking. Another aid may be the opportunity to recognize the toil as well as the glamour of the professions and administrative business. The individual who gives as his occupational life choice "retired capitalist" might not choose to follow the hard road that leads to this final goal. Exceptions in terms of unrewarded labor or untaxed leisure and ease will continue to tantalize and provoke the thoughtless. Again it is obvious even to the most casual observer that innumerable factors are involved. Other correlates of both intelligence and achievement are probably always present. Physical and mental health, for example, or the assets of a favorable ancestral inheritance enter in conspicuously, and in certain, perhaps many, instances these clearly outweigh intelligence and so account for important individual deviations from the expected trend.

Measurements of adults throughout the life span confirm the earlier studies of children and adolescents in showing that intelligence is closely related to achieved adjustment in every age period, whether in educational, economic, or occupational terms. The table that follows indicates in a general way this relationship between intelligence level, degree of education, and type of occupation.

I.Q. SCALE WITH ACHIEVEMENT EQUIVALENTS

| *Intelligence and education* | *I.Q.* | *Occupation* |
|---|---|---|
| Genius and near-genius | | Inventors, specialists |
| Prize men, *summa cum laude* | 140 | Professional and industrial leaders |
| Ph.D. and M.D. *cum laude* | | Army officers (professional branches) |
| College graduates | 120 | Professions and business |
| High-school graduates | | Army officers |
| General population (average) | 100 | Clerical and skilled labor |
| Grade-school graduates | | Draft army (white) |
| Dull mentality | 80 | Semi-skilled labor |
| Border-line mentality | | Unskilled labor |
| Feebleminded | 60 | Directed unskilled labor |
| Imbeciles | | Directed tasks |
| | 40 | |
| Idiots | | |
| | 20 | |

Throughout the life cycle, the intelligence scores of groups cluster about the means for their respective educational levels, whether grade-school, high-school, or college. The economic and occupational hierarchies recruit their ranks in predictable intellectual terms, and the presence of individual deviations or contradictions merely proves the rule and incites to the study of other personality factors by indicating a compensatory excess in one of them in a recognizable, if not yet precisely measurable, form.

*Intelligence and Social Adjustment Within the Hierarchies.*—Intelligence enters into the picture of human adjustment to determine in broad terms not only the educational, economic, and occupational placement of groups within total populations, but also and more specifically the higher or lower status of an individual within the group itself. Thus, intelligence scores made in childhood or youth have been found fairly reliable indicators of later individual academic progress and achievement. Economic progress and occupational achievement may likewise to some extent be predicted for individuals, especially if other personality factors are also known. A few recently reported studies will illustrate the trends.

Intelligence scores persistently point to individual success in school work at all levels. Class leaders in the grades become the college population, and the college graduates *cum laude* are distinctly superior in intelligence to the generality

of the superior. Proctor reports that of 1,500 high-school students given a group test of intelligence in 1917, the average I.Q. of the 560 who could not be located thirteen years later was 93, that of the 940 individuals who could be located, 108. The rank of the vocational status attained by these subjects in thirteen years was found to be significantly related to the I.Q. recorded for them while in high school, and also to the duration of their schooling.

In business and industry typical findings show the trend of individual adults toward a level comfortable for them in terms of intellect. Following the testing in intelligence of the entire force of a California utility company, Wadsworth reports a correlation of .68 between scores and supervisors' man-to-man estimates in terms of "relative value to the company." A comparison of employees hired prior to the adoption of testing and those hired on the basis of test standing indicated a reduction of unsatisfactory employees from 29 per cent to 5.5 per cent of the total force.

From a two-year study of 550 men in a large Eastern life-insurance company, Schultz reports on intelligence and personality scores as indicators of ability to understand the job and instructions and to profit from training and experience, and specifically on selling ability. Combined test scores indicated the 70 per cent who, when hired, proved to have the best production records, and also the 70 per cent who, if hired, would have been quite unsuited to the job. The intelligence tests proved of most significance in the selection of assistant managers.

In the Westinghouse Company employees have been hired, transferred, and promoted on the basis of tests, with results stated as follows by Armstrong: The tests help materially to select applicants who will adjust and be successful even when they have had no previous training. They reduce turnover, help to eliminate partiality and favoritism, help to establish objective standards, and raise the standard of applicants. A sizable correlation (.8) is found between test standing and department manager's ratings. Transfers and changes based on test results raise morale, increase efficiency, and stimulate special study looking forward to further promotions.

Intelligence is repeatedly mentioned as a factor in personal

adjustment to daily routine and to special life problems. The incidence of behavior difficulties in children is probably somewhat less among the more intelligent. Physicians and nurses report more adequate coöperation from those who show in other ways also that they are the more able mentally, and psychoanalysts usually limit their studies and therapy to average and above-average individuals.

*The Extremes of Intelligence.*—Comparison of the least with the most intelligent twentieth of the general population illuminates the intelligence-adjustment relationship by showing the contrast between typical patterns of social adjustment at the two extremes. Let us first consider the feebleminded. Bleuler says:

> "Although in the oligophrenias we deal with a general disturbance of the cerebral cortex, the weakness of intelligence alone stands out as the principal symptom of these diseases. For the weakness of intelligence is not only of the greatest practical importance, but the very cerebral anomalies that come into consideration represent in a certain relation quite a uniform simplification of the intellectual apparatus, whereas other functions like the instincts and affectivity need not necessarily be affected, or even when deviating from the normal they radiate into the most dissimilar directions and show nothing that is typical of imbecility.
>
> "The oligophrenias comprise not only the congenital disturbances, but also those that were acquired in early childhood. . . . The weakness of the association and the existence of the disease during the bringing up stamp the whole group with something characteristic symptomologically, and what is more, with something of common practical importance.
>
> "The oligophrenias are, in part, simple aberrations of the normal, and even in cases where a definite morbid process produces the mental weakness, it may be hardly perceptible. The pathological group cannot, therefore, be separated from the normal into which it gradually changes through mental *debility* and *narrowness*, or through stupidity. But even within these entities there are only fluctuating transitions on a psychic basis. One designates as *idiots* in a general way patients of a higher degree who cannot acquire any school knowledge or who are absolutely unfit socially; as *imbeciles* patients who do not advance beyond the position of common-school graduates, or those who can still mix in human society and can even perform some subordinate services; and as mental *debility* one diagnoses those who come to a standstill in the development after the public school or who in simple relationships can still maintain themselves somewhat independently; that is, they fail when confronted by the average demands."

A few cases described with reference to the measured intelligence will illustrate these categories.

F.Q. is the offspring of a feebleminded mother and a dull-average father. He first walked at the age of three and has never learned to say more than a dozen words meaningfully. He imitates the sounds heard in sentences, but without appropriate significance. He can feed himself, using a spoon, and has at length learned to dress himself if the clothes are given to him one at a time. He does not persist in any activity without continued stimulus and specific help. He cries when he is hungry and he knows where the food is kept, although he has never learned how to get it for himself. This child is an idiot, I.Q. 25–30. Children like him seldom enter school.

G.N. is from a superior home environment. His father, a college graduate, is a teacher. The mother had two years of college work. An older sister has above-average intelligence. The parents have given careful thought and attention to the training and development of both children. Medical attention has been of the best. The girl is doing good work in high school and preparing for college. The boy attended private nursery schools and grade schools until rejected because he required too much of the teachers' time and was making practically no progress. Now in a state institution for the feebleminded he has made a good adjustment and seems happy in his play and duties. He can talk appropriately about things of interest to a five-year-old. He may develop to the six- or seven-year mental level. His I.Q. is 45–50. Imbeciles like this are occasionally found in the first, less often in the second grade, in the public schools.

L.Y. was ten when I saw her. Her mental age was approximately 5½ years. Her father is a laborer; the home conditions are poor. Other children in the family are known to be of low-grade mentality. L.Y. has entered a country school for three successive years, only to be sent home by the teacher, because she cannot learn and her behavior is "silly." The other children do not accept her or her brothers in their play. She may develop to a mental age of 8 or 9. Her I.Q. is 55–60.

N.W. is twenty years old. He is small of stature and active. He runs errands for his grandmother, with whom he lives. But she cannot trust him alone any longer, as he makes fires in the cellar and steals articles from the neighbors' yards. He has an I.Q. of 60–65 and will probably not develop beyond a mental age of 9 or 10.

S.D. is sixteen. She has attended a special class at school for the past five years. Her attendance and conduct are good. She works faithfully at school and asks for special assignments to take home, although this is not required. She likes to teach what she has learned to the little children who live near her home. She is never cross except when they refuse to learn. She hopes to be transferred back to the regular school and after eighth-grade graduation to attend high school and then become a teacher. But S.D.'s I.Q. on four tests in successive years ranges from 65 to 71. It may be necessary later to place her in a home for the feebleminded.

B.R. is an attractive-looking girl whose father, after becoming addicted to alcohol, became a wanderer. The mother was a complainer, shiftless and immoral. An older half-sister, who is self-educated and who has held her present secretarial position with satisfaction for more

than ten years, assumed responsibility for this girl, hoping to give her the opportunities that she herself had missed. But B., who is now seventeen, has been a constant source of disappointment. Always cheerfully promising to do better, she has become less and less regular in school attendance and has made friends with a group of wild, irresponsible boys and girls. She has stayed away repeatedly overnight without informing her sister of her whereabouts. Now she states that she is married to a young sailor lad, who, however, has left her for parts unknown. Psychological examination reveals school-achievement scores at the third-grade level, a mental age of 11½, and an intelligence quotient of 72–82, with reasoning and judgment typically feebleminded.

M.R. was eighteen years of age when first examined psychologically. His parents state that he did not develop as rapidly as his brother and sisters, but they were advised that this was not infrequently the case with certain groups of children, and that he would probably catch up later. He was late in sitting up and in walking. He has always had fairly good health, no accidents or serious illnesses. He attended school for ten years, always studied hard, but twice failed to be promoted. At sixteen he graduated from the eighth grade and entered a manual-arts high school. Here he seemed less happy and well adjusted than before; he lost interest in the work, could not concentrate, and began to go about with a group of older boys who had left school. Later it turned out that these boys were carrying on systematic burglaries in homes and stores in remoter parts of the city. M.R. was never permitted by them to enter any of the buildings, but was left outside to give the alarm. He was given 50 cents or some small trinket after one of these raids. The police brought him to the Boys' Detention Home, where psychological examination revealed a mental age of 11 years, I.Q. 69–79, with school-achievement scores at approximately this same level. Placed in a special trade school, M.R. learned to use carpenter's tools and became assistant to the shop carpenter in his uncle's mill, where he had continued for three years with moderate satisfaction when last heard from.

L.N. was seen by a psychologist first when he was twelve years old and in the fourth grade. He was reported to be backward and troublesome in school, a truant, quarrelsome with his brothers and sisters, addicted to lying and to stealing from his mother. The parents and the other children in the family are of high-average attainments and interests and comfortably adjusted socially. The father is a foreman in a large manufacturing plant. The home life is pleasant and congenial except for L's share in it. He is the youngest of six children. The others are doing well in school and they resent the constant petty annoyances caused by L., who is now failing of promotion in the fourth grade after repeating each of the previous two. He says the teachers are "always after him, shouting at him to work." His present teacher is often at her wits' end to know how to deal with him. She will gladly follow any suggestion. At this time he was found to have an intelligence quotient of 70, with a mental age of 8½ years. His school achievement in the basic school subjects was just a little higher than this and therefore approximately at the average level for beginning third-grade work. After two more years in the public school, he attended a private school

for a time, then returned to his first school at age sixteen, to enter the seventh grade. Now he became quite retiring and had few friends even among the younger boys. He was allowed to stay in at recess because he seemed so shy and uncomfortable among the other children. He is not a disciplinary problem except in so far as it annoys his teachers to see him doing nothing. He seems unhappy and has many minor physical complaints. At this time his I.Q. was 68, and placement in a trade school was recommended. Here he was among boys of similar abilities and capacities. Under a well-trained teacher, he became moderately proficient in shoe repairing; and since leaving the school, he has worked with fair success in a shop directed by a former trade-school instructor.

Children like these and adults of similar endowment can find their place in a society that cares to provide for them. There is suitable employment for every intelligence level—with the exception, perhaps, of idiocy—and much has been done, especially in some of the state institutions for the feebleminded, to discover the kinds of task at which various degrees of intellect can succeed. Louttit has brought together the information accumulated by many investigators regarding work successfully carried on by the feebleminded.[1] A few samples will illustrate the useful scale of employment in terms of mental age that he has built up. At mental age 5, are brush and net making, rope braiding, garden and stable work; at 6, farm work and work as bricklayer's assistant; at 7, plowing, caning chairs, truck driving; at 8, mattress repairing, cutting hair and shaving, making wooden toys; at 9, repairing furniture, painting toys, harvesting crops; at 10, printing, making forms for cement, operating gear-cutting machines, building auto tops, and serving as boiler-maker's apprentice. In general the work of the very dull and the feebleminded is characterized by its simplicity and by the absence of elements involving new decisions or responsible choices.

*Idiot Savants.*—Can we expect talent or genius ever to come from among individuals like these? Let us examine the reported cases of idiot savants, individuals reputed to be idiots or imbeciles, who yet possess extraordinary talent in some special direction. The known cases, says Pintner, seem to fall into two groups: First are those individuals of relatively low intelligence who have practiced a single small talent so that they can recite pages of a school reading book from

[1] See *Clinical Psychology*, by C. M. Louttit. New York: Harper and Brothers, 1936.

memory, remember birthdays and automobile-license or telephone numbers, or construct presentable articles of woodwork or colorful paintings. Second are those like Tredgold's genius of Earlswood Asylum, who was sensorially defective, deaf, uneducated, uncouth, and ignorant, but perhaps not feebleminded. He constructed elaborate models of ships, carrying out the designs in the greatest detail. The performances of the first group do not surprise the psychologist. They are the expression of special abilities in persons of retarded intellect. The second group may perhaps be similarly explained, but as we do not have a measure of the intellect we cannot say with any assurance. Tredgold did not believe that his man was "intrinsically defective." He may have been a person of more than average ability, all of which, owing to circumstances and his own interest, was turned in one particular direction. We may conclude with Pintner that "it is somewhat misleading to group such cases under idiot savants. They are not idiots and they are far from being savants."

*The Intellectually Gifted.*—At the other extreme of the intelligence range is another small fraction of the total population. From this fraction are drawn the more able professional workers and the leaders and creators of human progress. There is probably no scientific formulation, no artistic production, and no great industrial achievement that has not been made or initiated by an individual of definitely more than average intelligence. But if in any given population a line be drawn at the critical point in the measurement of intelligence under which no contribution to world progress has gone forth, we can by no means feel assured that the individuals who rate above this point will all make valuable contributions to the progress of society or indeed in some cases any positive contributions at all. The number of creative leaders is small, and a large population of persons with equal assets in the matter of intelligence, but without certain other assets of constitution and personality, probably makes up the bulk of individuals who rate as intellectually superior. In addition are those who have the superior intellect, but who are definitely handicapped by liabilities, emotional or physical. It is not enough to be endowed even with great gifts of

capacity and talent if these are not developed through experience, or if the motivation for this development is in some way lacking.

A few case studies of present-day children of superior mentality follow.

J.G. is finishing the eighth grade at twelve years of age. He is a healthy, rugged boy who plays on the school football team and rates in school marks within the upper fifth of his class. He has won a scholarship to a superior preparatory school and expects to go on to college. His parents have never urged him in his school work, but they have been interested in his achievements and have enjoyed his success.

L.T. is sixteen. She is in the third year of high school. She has worked as a mother's helper for the last two years. She had somewhat less time than she would like to devote to her studies and she regrets not being able to join in many of the after-school activities. She belongs to a scout group and a dramatic club, and she teaches the two children she takes care of little plays which she and they present for the family. Her best work at school is in English composition, but she is above the average in all of her work. This girl's father was a lawyer, her mother a student of art. The girl's mental age is 20+ her I.Q. 140–145.

J.W. is seventeen and is completing his preparatory-school work. He spent two years in a school in Switzerland, where he learned a fair smattering of French and German, so that he can read easily and converse superficially in both these languages. He has made a conchological survey of the region in which his vacations have been spent that is rated superior by experts who have seen it. His school work has always been excellent, although he never appears to study, and he has spent much time in reading, research, and discussion. He plays tennis and basket ball and is a violinist of some talent. His I.Q. was 155 when he was ten years of age, and there is no indication that his ability has waned.

Terman's studies of gifted California children[1] furnish us with a vast background for the understanding of well-endowed children like these. Followed from infancy or childhood to adolescence or early maturity, with an accumulation of intelligence and social data in historical and statistical form, this group gives an amazing revelation of the interests, energy, and wide range of desirable adjustments possible to able young Americans. The promise of early years has in most cases been borne out by later achievements. Individual test scores and I.Q.'s show fluctuations from time to time that

[1]See *Mental and Physical Traits of a Thousand Gifted Children* and *The Promise of Youth; Follow-up Studies of a Thousand Gifted Children*, by Lewis M. Terman. Vols. 1 and 3 of *Genetic Studies of Genius*. Stanford University: Stanford University Press, 1926 and 1930.

are of technical interest to psychologists, but the quality and quantity of the mental-test performance of the individuals in the group, their intelligent acts, and their superior social achievements give persistent evidence of personality assets and investments measurably superior at every point to those of average children.

In contemplating the achievements of gifted youngsters of to-day, the question may rise in many minds: Were men of notable world achievement distinguished in childhood by the kind of ability displayed by these gifted Californians? In answer it must be said that test scores made in childhood are not as yet available to any considerable extent for distinguished adults. Intelligence can, however, be rated in terms of behavior known to be highly diagnostic of superior mentality, such as educability, type of interest expressed in successful action, and age of remarkable achievement. Some examples will show that the childhood and youth of the eminent were prognostic of later development, and that the individual-achievement pattern, like that of contemporary children of high I.Q., is not in any obvious way chiefly conditioned or largely limited by environmental factors.

Horace Mann, the son of a farmer in limited circumstances, was obliged to procure by his own exertions the means of obtaining an education. His school books he earned by braiding straw. These, and such other books as he had access to in early life were, as he informs us, "few and their contents meager and miserable." "My teachers," he adds, "were very good people, but they were very poor teachers." There was, however, no lack of hard work in his severe and frugal life, and in summer manual labors often encroached upon the hours that should have been devoted to sleep. With all these disadvantages, his mind yet gave early proof of uncommon power and intense activity. At about the age of twenty he began the study of Latin and in six months prepared himself to enter the sophomore class in Brown University. Here he graduated with the highest honors at the age of twenty-three, presenting, as a graduating address, *The Progressive Character of the Human Race.* Shortly after his graduation he married the daughter of the president of the university. After studying law for a brief period, he accepted a position as tutor in Latin and Greek, which he held for two years, followed by a second two-year period as college librarian. Returning to the law, he studied at the famous school in Litchfield for two years, was admitted to the bar at twenty-seven, and at thirty-one was elected to the state legislature, where he devoted himself to the interests of education and social welfare. It was said that during the fourteen years of his law practice he gained four out of five of the contested cases in which he engaged.

Thomas Jefferson had a more favorable family background. His father, a surveyor, was a justice of the peace, a colonel, and a member of the House of Burgesses. The son's thirst for knowledge was insatiable and he seized all means for satisfying it. Before he was fifteen he had read all of the books in the parental library, and at seventeen he was already noted for scholarship and industry. He engaged in athletics, played the violin, maintained an interest in languages, and was deeply attracted to mathematics. At the age of twenty-three he completed a self-directed course, with special emphasis on the law, having developed a capacity for deep, thorough, and prolonged study in all branches of knowledge. At twenty-four he was received at the bar, where he made an immediate success of his profession.

Humphrey Davy came of yeoman stock; but his father was a rather shiftless man, a wood-carver. The boy, a strong, healthy, active child, walked at nine months and spoke "fluently" at two years. He could recite a great part of *Pilgrim's Progress* before he could well read it. He early developed a taste for natural history, had some talent in drawing and painting, and his reading and study covered a wide range. He maintained the lead in his class without any special effort and was thought a clever boy. At sixteen he was apprenticed to a surgeon and apothecary of recognized note. During the next years he read widely in medical works, but did not neglect other subjects. He learned the technique of surgery, and at eighteen or nineteen began the study of chemistry. At twenty he published two scientific papers, and at twenty-two his discovery of nitrous oxide and its effect on man resulted in his appointment to a lectureship at the Royal Institution in London. His investigations now included studies of tanning, electro-chemistry, and agricultural chemistry. His achievements were recognized, and at twenty-three he was promoted to a professorship.

John Milton, of well-to-do, cultured parentage, was a poet from his childhood. At the age of twelve he was already known for his "impetuosity in learning," and in the next years he seldom left his lessons for bed until midnight. His first extant compositions are the paraphrases of two psalms, which date from his sixteenth year. He entered Cambridge at sixteen, and received his Master's degree at twenty-three. He studied intently, but produced numerous elegies and other poems in Latin and English, including the *Ode on the Morning of Christ's Nativity*. At home, from his twenty-fourth to his twenty-sixth year he studied the classics, music, and mathematics, and wrote many poems, including *L'Allegro*, *Il Penseroso*, and *Comus*.

George Berkeley's family belonged to the gentry. Of George it is reported that his interest in philosophical speculation developed at the age of eight. He was the youngest boy to enter the second class of his school, and probably also the youngest to pass from it to the University of Dublin. He was eccentric and was regarded by his associates as either the greatest genius or the greatest dunce in college. His intimates rated him a prodigy of learning. At seventeen he became a scholar of Trinity College, at nineteen received the B.A. degree, at twenty-two the M.A., passing his examination "with unprecedented applause." At twenty-four his *Essay Toward a New Theory of Vision* appeared, and in the same year he issued the *Treatise Concerning the Principles of Human Knowledge*, which contains the leading thought and method of his earlier philosophy.

Michelangelo's father was an impractical, easy-going individual of no profession, who tried to discourage his son's early interest in drawing because he did not wish a painter in the family. However, the boy showed such activity and precocity in art that the reluctant parent was finally persuaded to apprentice him to distinguished teachers, under whose direction he developed remarkable skill of hand. At the age of thirteen he was so proficient that he received a salary, although then only in the first year of his apprenticeship. At fourteen he was chosen as one of two from his school to attend the Ducal Art School. His passion for his art was so great that he made use of every available space as a sketch surface. His work even at this early age is reported to have "caused wonder to all who saw it." His teacher, when he saw the drawing of Michelangelo at fourteen, exclaimed, "This one knows more about it than I!" The Mask of a Faun, his first known work in marble, dates from his fifteenth or sixteenth year. Four masterly works of art are known to belong to the period before he was twenty. Before he was twenty-five he had completed the Madonna of Bruges, which has been said to hold in sculpture the position that the Sistine Madonna holds in painting.

From data like these in somewhat more detail [1] it has been possible to reach the conclusion that artists, including Raphael, Rembrandt, and Michelangelo, rated not less than 130 to 180 in average childhood intelligence quotient. Poets and other writers, including Byron, Chatterton, Carlyle, Coleridge, Hugo, Goethe, Milton, and Voltaire, rated as a group not less than 150 to 180. Musicians, including Weber, Mozart, and Beethoven, rated 150 to 170; statesmen—Pitt, Peel, Lincoln, Cavour, Grotius—145 to 200; scientists—Kepler, Liebig, Haller, Linnæus, Jenner—145 to 180; philosophers—Berkeley, Leibnitz, Humboldt, Mill, Hegel, and Kant—150 to 200. The extraordinary distinction of these geniuses seems to have been evidenced in their childhood as in later years, and so for them, as for less notable folk, a prediction of future distinction based on childhood behavior would not have been seriously misleading.

Before concluding, I should like to mention briefly two special problems. The first is the question of the relation of intelligence and crime. The second is the question as to the persistence of the behavior at a given intelligence level that may be predicted at any given period. It is, in a sense, the question of the constancy of the I.Q. or intelligence index.

*Intelligence and Crime.*—Soon after the discovery of a

[1] See *The Early Mental Traits of Three Hundred Geniuses*, by Catharine M. Cox. Vol. 2 of *Genetic Studies of Genius*. Stanford University: Stanford University Press, 1926.

fairly reliable measure of intelligence which correlates with desirable human achievement, enthusiasts looked for a speedy segregation of potential criminals and social offenders by the identification of children of low intelligence. This understandable hope was not to be realized because of the lack of correlation between intelligence and criminally non-social performance. The essential difference between the criminal and the non-criminal individual seems not to be primarily an intellectual one, but depends rather on some other personality factors, on social training, experience, and point of view.

It is true that criminals as a group have a lower intelligence than the mass of humanity, but they probably do not always have a lower mental ability than the social group from which they are recruited. In general, our measurements of criminals must be drawn from individuals who have come into conflict with the law, and it may be that their lower level of intelligence, as compared with that of the mass of humanity, is an indication not so much of the relation of mental ability to crime as of the fact that the more intelligent criminal escapes detection, or in some instances uses his greater competency to modify specific public opinion in its attitude toward his crime or toward him as a criminal.

In our recent Connecticut jail survey, we found 11 per cent of the group above average in intelligence as compared to 17 per cent of the United States white draft for this state; at the average level, 35 per cent of the jail men as compared to 44 per cent of the draft men; at the dull level, 25 per cent of the jail men, 20 per cent of the draft men; of border-line intelligence, 18 per cent of the jail men, 10 per cent of the draft men; feebleminded, 12 per cent of the jail men, 9 per cent of the draft men. These findings suggest that intelligence may be a factor in keeping out of jail, but probably it is only one among many others.

*The Constancy of the I.Q.*—Measures or indices of intelligence are known to change from time to time. Most conspicuous and characteristic are (1) the change from childhood to late adolescence or early adulthood resulting from the growth of the organism, and (2) the decline that occurs from early to late maturity. This great curve in the intelligence level, which may be observed of individuals from every social and economic group, conforms to the general pattern of physiological

growth and decline. And as the results of experience tend in maturity to afford means of offsetting physiological decay, so in the psychological experience of adults generally, the accumulation of knowledge and the development of techniques of mental organization make possible the maintenance of a relatively characteristic level of achievement even when the specific mental functions no longer act as quickly or possibly as effectively as in early maturity.

Beside the elevation of the intelligence level that comes through growth in the early years there is, I believe, at present no known acceleration or raising of the intelligence index in conjunction with or as an expression of a true change in the constitutional or organic capacity of the individual. We have no evidences of late maturing, whether gradual or sudden, following an early retardation in the realm of intellect, any more than we have in any of the physical organs.

The phenomenon known as the rise of the I.Q., other than that which follows the curve of psycho-physiological life development, seems to be attributable (1) to the removal of specific sensory or motor handicaps, such as the restoration of sight to a blind person or the overcoming of a specific handicap such as a reading disability; (2) a release of energy through personality adjustment, such as may come in an individual who has been suffering an emotional repression and is now relieved, either through the favorable accidents of experience or through some psychological, psychiatric, or psychoanalytic therapy; or (3) a better organization for the expression of intelligence, or a better motivation or stimulation to effort, or a better habit of persistence or continuity of work, such as may come through a course of special training.

The elements that lower the intelligence rating—or that appear to lower it—are the reverse of the above functional changes. These may come (1) through a limitation by a specific handicap, (2) through an inhibition of energy by reason of some emotional distress, or (3) through a reduction in the motivation or stimulation to output and a lowering of the persistence or effort level.

Fluctuations of the intellectual indices will, of course, not infrequently occur because of lack of precision in the instruments used, but within reasonable limits the measure of an individual's capacity can usually be found at a given time,

and sufficiently reliable predictions as to the course of development and decline can be made. In general, an experienced clinical psychologist can, through adequate study, determine the presence or absence of special or of characteristic hampering influences and rate the maximal or potential I.Q. accordingly.

Psychoanalysis has contributed to the understanding of this problem by laboriously studying and treating some feebleminded children. In these prolonged treatments, notably the work of L. Pierce Clark, it has been found that the emotional organization and the release of power were increased even in the very feebleminded through psychoanalytic procedures, but the maximal intelligence index was not materially altered. In our own study of an individual of superior intelligence under long psychoanalytic treatment, this same result has appeared.

In conclusion, I may perhaps refer briefly to the place of intelligence measures and studies in the wider analysis and investigation and for the better understanding of human personality. Studies of intelligence and intelligent behavior do, I believe, have a part to play, not only for their contribution to an understanding of the basic problem of social adjustment and to the prediction of probable educational or occupational success, but also for what they may contribute to the understanding of the personality as a whole and to the specific descriptive analysis and classification of the mental behavior, whether of normal, psychopathic, or psychotic individuals. Intelligent or unintelligent behavior, as observed by the psychologist, includes postural, manual, and verbal activity, and may involve evidences of visual, cutaneous, kinesthetic, or auditory sensitivity, influenced at the same time by emotional conditions, physical status, or other factors. Any or all of these may give intimations as to the strengths of the diverse mental functions and emotional expressions, and as the science of measuring progresses, we may come to understand better some of those other correlates with social adjustment which are at present not so readily measurable, but which are clearly as definitely significant as intelligence in the life adjustment of human personalities.

# A GROUP-CLINIC APPROACH TO DELINQUENCY

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THOUGH there are probation laws in every state in the Union, few provisions are made for enforcing the *intentions* of these laws. Early in the history of probation, it became evident that the courts could use the legal status of this new plan as an opportunity for abandoning interest and treatment in certain given cases. But probation was never intended to be a measure to make the disposition of justice easy and careless. Sutherland defines probation as "the status of a convicted offender during a period of suspension of sentence in which he is given liberty conditioned on his good behavior and in which the state *by personal supervision* attempts to assist him to maintain good behavior,"[1] and this "personal supervision" demands that an active, studied effort of reconditioning be provided for offenders during a trial period. That a large percentage of probationers fail during this trial period is due to the fact that no such active effort of reconditioning is offered. There is no inherent magic in a court appearance, or in a weekly visit to a probation officer, which will guarantee cure for those problems of long standing that find their way into a court. It is also interesting to note that even in many large courts, where competent staffs have been established to handle cases, so much time is spent in *investigating* the delinquency, in examining and *studying* the problem, and in keeping records, that no time is left for the *treatment* of the individual delinquent himself.

However, the record is not such that we can assume that nothing has been attempted in the treatment of delinquents. Much has been attempted, with varied results. The question

[1] *Principles of Criminology*, by Edwin H. Sutherland. Philadelphia: J. B. Lippincott Company, 1934. p. 350.

is, as it always has been, Along what lines can treatment be instituted? A brief discussion of this fundamental problem seems to us to be pertinent.

At the outset, if our probationary period is to be concerned with other than the mere conviction and court tie-up of the youthful malefactor, one is confronted with two closely allied questions relative to the treatment of delinquents. The first is, What type of treatment do these boys need, or, better, from what type of treatment will they profit best, assuming that "profit" in this case means a self-imposed abstinence from further antisocial activity? Specifically, do we mean that these boys shall be regarded as definite personality deviates and hence to be benefited by an intensive individual approach by means of the well-recognized psychotherapeutic techniques now available? Or shall they be regarded as essentially "normal" beings, whose delinquencies arise, almost inevitably, from inability—because of lack of knowledge of communal rights, wrongs, privileges, and responsibilities—to adjust themselves to an environment that is, almost without exception, harsh and antagonistic? Until a frank and realistic impression, gained from a study of our past successes and failures in *treating* these boys, aids us in clarifying this point, we shall continue to note the despairing results of wrongly directed energy and expenditure.

The second, but, it would seem, equally important, question is, How much in dollars and cents can society reasonably be asked to pay for any mode of treatment in our attempts to turn initial delinquents from further crime? Certainly, realism in thinking is needed here, too.

It would seem, however, that we *have* progressed to the point where we can safely ask ourselves one question, in relation to the *individual* delinquent before us, that may aid us in formulating the mode of treatment and follow-up most beneficial to him and to society: Does this boy's tendency to antisocial acts have its basis in a serious personality disorder that calls for searching psychiatric study? If this question is answered affirmatively, the delinquent should be transferred to a psychiatric clinic for treatment, and the psychiatrist and the juvenile court should agree as to the length of his probationary period.

Yet, as one observes the cases that pass through the juvenile court over a period of years, one is convinced, even though a psychiatrist one's self, that the great majority of these boys are not cases for long, intensive, individualized psychiatric therapy, but rather that they are problems of a sociological and educational nature—problems involving an appalling lack of knowledge, on their part, about group living, group responsibility, group demands. It is well for society that such *is* the nature of this problem, because were it otherwise—were it certain that 95 per cent of delinquents would profit only by individual psychiatric treatment—society simply could not support staffs large enough to give what to-day would be considered adequate psychotherapy. Finally, it is generally agreed by able psychotherapeutists (1) that individuals of dull-normal or border-line intelligence profit least from psychotherapy; and (2) that individuals in the "in-between age" (from twelve to fifteen years) may be definitely harmed by certain types of psychiatric treatment. It is children of this age group and these intelligence levels who are most often presented to the court as juvenile delinquents.

Hence we feel that, side by side with an agency to care for the sporadic psychiatric case, there must be also an agency whose prime purpose it is to give intensive, well-directed, and well-supervised *group* therapy to the great bulk of boys placed on probation by the juvenile court. Such group study and therapy should be designed to afford a foundation for the continuation of treatment to be carried out by the neighborhood clubs and agencies to which these boys must be turned over during the course of their probationary period. In other words, it should be in the nature of a much needed "clinic" interposed between the courtroom and the affiliated boys' work agencies throughout the city. Such a clinic for carrying out a program of group therapy with probationers has been created recently by Judge John F. Perkins of the Boston Juvenile Court.

### THE SPECIFIC PROBLEM

The Citizenship Training Department was established to meet three specific needs which the court felt must be met before any degree of effectiveness could be expected from the probationary period.

1. Not all boys placed on probation have equally serious problems. It seemed important, therefore, to send all boys through a preliminary period of study to determine the seriousness of the problem of each, from the standpoint both of the boy's personality and of his delinquency. With such information a more intelligent sorting of the cases could be made. Those with deep-seated problems would be given intensive treatment by the psychiatric clinic and those with only slight difficulties would be carried with a minimum of supervision in the training department, and later through other established social agencies.

2. The effectiveness of many social agencies allied with a crime-prevention program is lost by the acceptance from the court of cases that are not yet ready to profit from the group activities offered to them. There is, therefore, need for preliminary study, observation, and supervision to prepare the boy for the necessary steps in his real program of rehabilitation in his neighborhood house. In a city such as Boston, with its many specialized centers for follow-up and supervision, the court was not to assume the real burden of treatment, but rather to attempt to *prepare* the boy for his advent into these centers.

3. The third need was that of putting into effect an intelligent program of probation with the available community resources. The emphasis was to be on treatment. Not that the Citizenship Department was to become a specialized treatment center; instead, it was to make sure that treatment was carried out in one of the many centers already in operation in the city. After its preliminary study of a boy's problem, and after making a preliminary *preparation* for treatment, it was up to the department to furnish the machinery for initiating and checking the real follow-up—in psychiatric clinic, settlement house, foster home, church, or camp.

### ORGANIZATION

*Case Selection.*—All boys between the ages of thirteen and seventeen who are placed on probation by the Boston Juvenile Court are sent to the Citizenship Training Department. An occasional twelve-year-old is accepted if special needs demand it.

*Headquarters.*—Headquarters are maintained in a recreational center, the Boston Y.M.C.U., which is in the heart of the downtown district of Boston, about one mile from the court. Four rooms are used by the department—one for an office, one for an interview room, and two for classrooms. The gymnasium and basket-ball floor are available to the department at certain specified times of the day.

*Time.*—The boys enter the class on the Monday after their court appearance, and attend five days a week for seven consecutive weeks, between the hours of 4 P.M. and 6 P.M.

*Schedule.*—The two hours are divided as follows:

| | |
|---|---|
| 4:00–4:45 | Gymnasium work. Monday, Wednesday, and Friday are devoted to setting-up and conditioning exercises. (The department provides the gym suits.) |
| 4:45–5:00 | Shower. |
| 5:00–6:00 | Discussion classes on Monday, Tuesday, Wednesday, and Thursday. Testing and conferences on Friday. |

*Staff.*—The staff consists of a director who is trained in clinic and group methods, an examining physician who comes in twice a week from one of the city's pediatric clinics, and a consulting psychologist who comes in weekly from one of the city's psychiatric clinics to attend a case conference with the director, the examining physician, and the worker who carries out the follow-up work. The follow-up worker is on the permanent staff. His duties are to execute the follow-up program of treatment outlined at the end of each boy's experience in the Citizenship Training group. A full-time stenographer keeps all records and correspondence for the department.

*Advisers.*—An advisory committee made up of representatives from the City Wide Boys' Workers Conference of Boston has deliberated with the court from the very beginning of the experiment.

*Finances.*—Funds to carry on the work have been provided by three foundations and several individuals.

*Relation to the Court.*—The department works directly under the judge and the chief probation officer. In this way the court can control the direction of the development and meet the specific demands of the judge and his probation officers.

### STUDY OF THE DELINQUENT

The first task of the Citizenship Training Department is to set up the machinery and methods for a thorough study of each boy. As all the boys on probation are sent through the department, it is necessary to select methods that will permit the handling of at least fifteen or twenty boys simultaneously. For this purpose it is found that clinical and group methods can be coördinated. These two approaches, which traditionally have been used separately, are found to supplement each other strikingly to produce a much more complete picture of the boy than is produced by either method used alone. Clinical and group methods are combined in the following ways:

1. *Medical Examination.*—Every boy is given a thorough medical examination on the day he joins the class. As the first hour of every period is devoted to gymnasium work, a physical examination is a normal prerequisite for entrance into the gymnasium class. As the examinations are made in a room adjoining the gymnasium, the boys have accepted it as a necessary step to determine whether they are fit to undertake strenuous physical exercise. If the examining physician is not satisfied with his findings at the time, he will enlist the boy's interest in entering the hospital clinic for further examination.

2. *Psychological Tests:*

a. *Intelligence Test.*—A Dearborn group test is routinely given to every group of boys coming into the class. If it is felt that the group test is not representative, or if some boy is unable to take a group test, a Stanford-Binet rating is made.

b. *General Personality Tests.*—The boy is not submitted to a burdensome amount of testing at any one time. The personality test is used as an exercise in mental hygiene. During one period the boy fills out a Rogers test of personality adjustment as an exercise in facing himself. The next period he uses the test as an outline for discussion. The tests are collected after the second class period. Frequently the boy does not know that a test has been given; he accepts it merely as an exercise in mental hygiene.

In certain cases, where the problem is difficult to determine, a Rorschach test is administered.

3. *Physical Fitness Test.*—In an approach which begins with physical activity, there is a real possibility of interesting the boy in muscular development and good body hygiene. Rogers' test, called the "Physical Fitness Index," [1] has been found very helpful in determining whether a boy has an average amount of energy for his height and weight.

4. *Observations of the Individual.*—There is a growing consciousness that a child's problem cannot be formulated unless the child has been *observed* in a variety of social situations. The face-to-face laboratory set-up relied upon in most clinics does not offer a wide enough range of observation upon which to make judgments. Dr. Margaret E. Fries opens an article in a recent issue of MENTAL HYGIENE as follows: "A child playing with other children frequently acts differently than when observed in company with his mother, his family, or alone. One gets an incomplete picture when relying only on personal interviews with parents and children in the clinic or home." [2] Joseph Galkin also, in commenting on the same problem, says, "Case-work with delinquents and problem children can be very sterile if we see the client only as he reacts in the limited area of the interviewing room." [3]

The group set-up which is used in the Citizenship Training Department permits a wide use of the technique of observing a boy in a variety of situations. For instance, the locker room, in particular, is a place for free expression. The follow-up worker permits things to happen there without any great amount of supervision. He reports in detail conversations of the boys, typical behavior, and the response to any discipline that may have been meted out in the gymnasium. Free play in the gymnasium, acceptance of responsibility, discussion of important problems, work on a hobby—all offer important opportunities for objectively determining a boy's habitual modes of behavior. This, in turn, offers an indispensable check upon the surmises that result from the interviews and

[1] See *Physical Capacity Tests*, by Frederick R. Rogers. New York: A. S. Barnes and Company, 1931.

[2] *The Value of a Play Group in a Child-Development Study*, by Margaret E. Fries, M.D. MENTAL HYGIENE, Vol. 21, January 1937. p. 106.

[3] "The Treatment Possibilities Offered by the Summer Camp as a Supplement to the Child Guidance Clinic," by Joseph Galkin. *American Journal of Orthopsychiatry*, Vol. 7, October 1937. p. 474.

tests. For example, in the case of Joe X., observation in the Citizenship Training group disclosed the following:

> "In the locker room he isolated himself completely from the rest of the boys. On the basket-ball floor he played in a very erratic manner. For one quarter he would hang back, displaying no sign of interest. The next quarter he would come dashing out, throw the ball with great violence, and 'rough up' the opposing team. During a hobby period, when most of the boys pounded out ash trays, Joe X. destroyed two pieces of aluminum by violent blows. At the end of the hobby period he had two gnarled pieces of metal, whereas the other boys had ash trays."

Through observations such as these, made on each boy, one can estimate the reactions of the various boys to group situations.

5. *Observations on the Group.*—The group itself is also an important object of study, because of the light such observation sheds upon the problems of the individual boy. Seeing how the group responds to the boy, and, reciprocally, how the boy responds to the group, gives one insight into the social capacities of the boy and his effect upon other people. Fundamentally, delinquency is a failure to get along in organized group life. It would, therefore, seem imperative to study a boy in social settings in which his malfunctioning would naturally express itself.

6. *Crafts.*—We have experimented with a variety of crafts to determine their value in studying a boy. Some of those used are leatherwork, metalwork, carving, clay modeling, and finger painting. The value of such techniques is illustrated in the case of Bill R., who was asked to try to represent in a picture "the happiest moment in his life." He drew an ice wagon with a horse, and himself driving. In explaining this, he told about his great interest in animals, his pleasure in driving for the ice man, and his desires regarding his life work. The picture unloosed, in a natural way, a whole stream of conversation regarding his wishes, his interests, and the happy experiences in his life. Material of this type, gained spontaneously in the craft room, often becomes our most valuable guide for further investigation of a boy's personality, interests, and needs.

7. *Interviews.*—The interview is used throughout the seven weeks a boy is in the Citizenship Training group. The day the boy is assigned to the group, he is sent to the director by the

judge, not to be questioned about his delinquency, but to be told about the opportunities that lie ahead of him. On Thursday evenings a report card is made out with the boy, to be taken to the probation officer the next afternoon by the boy himself. This offers a splendid opportunity for using the interview in going over any problems that may have come up during the past week. At any time in the gymnasium or in the classroom a boy can be unobstrusively called aside and problems or progress can be talked over, and one morning is left open for private interviews such as may develop from the experiences of the week. A final interview is arranged with each boy when, at leisure, the whole experience in the Citizenship Training group may be talked over, and plans for the future outlined.

8. *Social History.*—The social history of each boy is prepared for the department by the probation officer. As each district of Boston has its own probation officer, the investigation of home, school, club, and church is naturally the duty of this man.

9. *Final Conferences Concerning the Boy.*—Two conferences are held to summarize the findings of the seven weeks and to formulate the problem.

a. On Monday of the last week a boy is in the Citizenship Training group, all the material is reviewed in a staff conference, attended by the director, the examining physician, the consulting psychologist, and the follow-up worker. A plan of treatment is outlined at that time which is specially gauged to meet the demands of each outgoing boy.

b. On Thursday of the same week the plan outlined in the first conference is submitted to the judge and probation officers for their approval.

10. *Conclusion.*—A concluding summary for each boy studied is drawn up under the following outline:

*Name* *Dates of Attendance* *C.T.G. No.—*

*Physical Data*

1. Medical Examination
2. Physical Fitness Index

*Test Results*

1. Intelligence Tests
2. Personality Inventory
3. Special Tests

*Summary of Behavior in the Group*
1. Attendance
2. Summary of Observations

*Boy's Own Story*

*Social History*

*General Summary*
1. The Boy's Problem
   a. From the standpoint of *Personality*
   b. From the standpoint of *Delinquency*
      1. Boy's General Attitude
      2. Boy's Standards of Values
      3. Boy's Delinquent Habits
      4. Boy's Ability to Live in a Group
2. Recommended Treatment
   a. General Treatment Hints
   b. Specific Treatment

Three copies of this summary are made. One is given to the probation officer in charge of the boy; one is given to the judge and chief probation officer for their joint use; one is filed with the case record in the Citizenship Training Department.

### TREATMENT PROGRAM

The neglected side of most probation programs has been the treatment aspect. Any number of agencies can be consulted to tell the court what is wrong with a boy, but few wish to tackle the real problem—namely, treatment. It is on this aspect that the Citizenship Training Department has centered its main attention.

It has been stated above that the Training Department cannot carry to completion the treatment of each boy; rather, its rôle is the preparation of the boys for the necessary carrying on of the training by those agencies especially fitted for this task. Our work with each boy for seven weeks permits some treatment emphasis, and particularly does it enable us to determine the best possible agency tie-up for the individual boy upon his "return" to his neighborhood affiliations. We have adopted certain principles as guides in building a treatment program:

1. We are not interested in treating symptoms—that is, the delinquency *per se*. The delinquency usually is only one aspect of a socio-personality problem which needs broad interpretation and understanding, and, in turn, requires that the boy be treated as a social unit. As we have stated, one cannot

approach this problem as one involving personality deviates alone.

2. Delinquency, as a violation of some group standard, demands that *social* insight be included in any plan of treatment for this problem. Experience has taught us that most delinquent boys have no conception of the manner in which laws, institutions, customs, and traditions have been evolved, or of their functions in maintaining a useful social order. On the other hand, they have experienced social institutions as irrational, repressive forces and hence have developed basic antagonisms toward police, courts, schools, and so on. This demands a special program of treatment which centers its attention on the manner in which groups preserve harmony and order in the interests of the individual. Antagonisms toward police, courts, and schools must be altered by certain minima of training and discussion relative to the growth, function, and problems of these institutions.

3. Too often our treatment in the past has depended upon a passive state of the delinquent. We have established as one of our guiding principles of treatment the emphasis upon the *self-activity* of the delinquent himself. It is he who must do the acting; it is he who must make the effort in his own behalf. This attitude we endeavor to inculcate from our very first interview with him.

4. An indispensable condition for effective learning is the opportunity for systematic practice. This holds true for the development of all skills, recreational or professional. It is equally true in learning the rules and habits of good citizenship. Hence, the opportunity to *practice* those habits and skills which make it possible for a boy to live peaceably in his community are offered during the training period.

5. All systems of therapy depend upon the building up of an effective working relationship between the worker and the delinquent. The artificial set-up which characterizes the ordinary clinic situation is not always conducive to the attainment of this working rapport. This is especially true in dealing with delinquent boys, for they frequently assume a resentful, reserved attitude which prevents the establishment of any kind of personal relationship. The group set-up featured in the Citizenship Training Department has been found particu-

larly useful in breaking through this reserve to a point where treatment can really begin. For instance, when John A. came into the group he was so rigid and resentful that he refused to talk with, or to make any contact with, other persons. He was quickly put off his guard when he found himself playing basket ball with the director—the therapist. He found the informal group activity so natural that he soon began to look upon the leader as a teammate and coach in whom he could confide. Such experiences are the rule rather than the exception in our first contacts with the boy.

These principles serve as guides in setting up the treatment activity of the Citizenship Training Department. Media for carrying out these principles are as follows:

1. *The Group.*—The group serves us as one of our most valuable devices for carrying on treatment with delinquent boys. The Citizenship Training group serves as a working model to demonstrate to a boy the skills necessary in all group life. A soccer game is frequently interrupted to point out the importance of teamwork, or the necessity of observing the rules of the game. The group also serves as a teaching unit to show individuals their own social deficiencies. For teaching purposes it is always wise to have models to illustrate the points under discussion. This is the advantage of working with delinquent boys in groups, for there are innumerable incidents and events to illustrate the basic needs of all group life.

Furthermore, there seems to be at work in every group certain therapeutic processes which have a tendency to socialize and normalize boys. Such processes as competition, conflict, group approval, group censorship, *esprit de corps,* integration, and so on, seem to be at work in every group, and these may be systematically studied and used as treatment media.

2. *Discussion Classes.*—Group discussion is undertaken four times each week for forty-five-minute periods. Such extensive use of the discussion technique is used because it has proved to be a ready means for carrying out several of our principles of therapy. Through these discussions we are able to talk about personal and social problems, and in this manner develop personal and social insight. Furthermore, it takes a large amount of teamwork, coöperation, and social

skill effectively to carry on conversation with fifteen or eighteen other boys.

We have found that there is a group level of thinking toward which nearly all members of the group eventually gravitate. If this group level is carefully planned and guided, though never superimposed, real modification in attitudes is frequently noted. In the light of our experience it seems fair to say that it is the group level of thinking which determines the modification in the attitude, rather than the *logic* of any lesson plan.

A topical outline of the seven-week discussion classes is as follows:

*First week—Physical Health*

1. "Health through Exercise"
2. "Health through Prevention of Disease"
3. "Health through Moderate Living"
4. "Health through Proper Food"

*Second week—Mental Health*

1. "Mental Health through Facing One's Self"

   On this day the boys fill out the Rogers test of personality adjustment as an *exercise* in facing one's self.

2. "Mental Health through Talking about One's Problems"

   The Rogers test is returned to the boys unscored. It is then used as the basis for discussing the problem of wishes, desires, friends, and so on. This discussion is carried on for three days. This second-week program has proved to be one of our most valuable means of getting a boy to talk about himself and his problems in an objective manner.

*Third week—How We Live Together*

1. Discussion Outline—"Unit I, The Group"
2. Discussion Outline—"Unit II, The Family"

*Fourth week—How We Live Together*

1. Discussion Outlne—"Unit III, The School Group"
2. Discussion Outline—"Unit IV, The Community Group"

*Fifth week—Problems a Boy Faces*

Here we get down to the level of the boys' problems. The entire group convenes on the first day and outlines a series of problems that are dealt with in small groups during the next two weeks. Sample problems that come up are:

"Easy Money"
Girls
Police
Poverty
Getting work
Leisure-time activity
Worry

*Sixth week—Problems a Boy Faces*

Discussion continues as outlined for fifth week.

*Seventh week—Lives of Interesting Persons*

1. Dr. George Washington Carver
2. Babe Ruth
3. Helen Keller
4. Dr. Edward Livingston Trudeau

Frequently a discussion begins with the entire group of eighteen or twenty boys. Then groups of six or eight are formed to carry on a more intensive attack on the problem of the day.

During the first year of our experiment, outside discussion leaders were frequently brought in to guide the group—persons interested in the problem under consideration. We have now abandoned this plan, having trained our own staff to furnish the leadership. Slides, movies, and discussion outlines are used as aids. This has made for greater unification in the teaching program.

3. *The Interview.*—The introduction of the group into the treatment set-up permits a marked elaboration of the interview technique. The individual approach is broadened by admitting into the interview incidents of failure and success that come out of the group experience. A striking example of this was noted one day when Joe R. found himself thoroughly disliked by the other boys. He wanted to know the reason for this. In a private talk we were able to point out that he was always telling the other boys what to do, and that frequently he came to the director with tales of the conduct of other boys. The group experience served as a precipitating medium for bringing out in the interview basic problems of this boy's personality.

Dr. Louis Wender has been similarly impressed by the results of introducing the group into a straight psychotherapeutic situation. He says, "Individual interviews are undertaken in conjunction with the patients, particularly in a group, and in many instances it has been found that the group stimulates the patient's desire for individual treatment, and that during these interviews such patients speak readily of experiences the discussion of which they had previously avoided."[1]

4. *Physical Training.*—It is possible, with any group of boys, to capitalize on their natural interest in physical train-

[1] "The Dynamics of Group Psychotherapy and Its Application," by Louis Wender. *Journal of Nervous and Mental Disease*, Vol. 84, pp. 54–60, July, 1936.

ing and athletics. We use this as a method of interesting a boy in his general development, the physical aspect being a tangible starting point for a general program of personality growth. Useful social habits, such as a sense of fair play, recognition of the rights of others, sportsmanship, team loyalty, are emphasized repeatedly during the gymnasium exercise. In addition, the "transference value" of interest in sports and games is considerable, when the boy returns later to the care of agencies in his own neighborhood.

5. *Direct Discipline.*—At times we find it necessary to place pressure on a boy in such a way that from it he experiences direct discipline. We follow Aichhorn in his belief that "it is incorrect to think that education means letting the child do as he pleases. Every one who has had anything to do with little children knows that restraint and prohibition of momentary impulses belongs to the order of the day and that the child must continually submit to limitations of freedom."[1] Delinquent boys are no exception to this rule.

Though attendance at the Citizenship Training group is not intended to be punitive, we try to inject enough discipline in the attendance and tardiness regulations and the general tempo of the program to avoid the danger of placing a premium upon lackadaisical attitudes or shiftlessness. The group itself often disciplines a boy. Donald C. always attempted to monopolize the discussion period with lengthy talks. Before long, the group had nicknamed him "The Professor" for his attempted erudition. After a time the impact of this nickname, coupled with pointed criticism in the locker room, imposed enough discipline to alter this boy's obnoxious behavior. Group discipline of this type occurs frequently, and not only renders pressure from above unnecessary, but brings about modifications of behavior patterns more effectively than that realized by censorship or punishment by the adult leaders.

6. *Practice in Taking Responsibility.*—From the minute a boy enters the Citizenship Training group, he is on his own initiative and must take responsibility; in fact, his responsibility begins before he joins. When a boy is assigned to the department by the judge, he gets a note of introduction from the probation officer to the director. It is the boy who must

[1] *Wayward Youth*, by August Aichhorn. New York: The Viking Press, 1935. pp. 193–94.

hunt up the headquarters of the department; it is he who is given responsibility for what happens. He takes care of his own athletic equipment; he does his own discussing; he makes his own effort in the gymnasium and in the classroom; he helps make out his own report card, which he takes himself to the probation officer. At the end of his seven weeks, it is he who must decide or agree on his program for the future. If a boy works out his own plan for staying out of trouble, it is rarely vetoed. For seven weeks the boy is thrown into a situation which demands self-activity, self-criticism, and self-determination.

7. *Medical Care.*—If there are organic difficulties which are found in the medical examination, treatment of these can begin during the time the boy is in the Citizenship Training group. The correction of obvious and humiliating physical defects in boys who show antisocial behavior for the first time will often eliminate the inferiority feelings that may, in some degree, motivate such behavior.

### FOLLOW-UP PROGRAM

The real effectiveness of the Citizenship Training Department depends upon the care with which the follow-up work is carried out. Study of the boy and initiation of treatment are merely preliminary steps leading up to the long-term program of rehabilitation necessary in most cases. As the city of Boston has innumerable agencies which are competent in many different fields, it becomes clear that our task is, in the main, to make intelligent use of the treatment resources already in existence. This involves study of the various treatment possibilities, the building up of working agreements with those selected, and finally provision of the machinery for transferring the treatment from the Citizenship Training Department to the coöperating agencies. Types of agencies with which we have working agreements for carrying out treatment are:

Psychiatric clinics
Hospitals
Foster homes
Clubs and recreational centers
Churches
Student supervisors for social-work schools
C.C.C. camps
A summer camp

In making this transfer we have at our disposal the staff follow-up worker whose main duties are to know the agencies personally and to see that the boys are taken to the centers for the real treatment experience. From time to time he checks back with the agencies to see what progress can be reported. He, in turn, relays this information to the director and the probation officers.

The probation officers themselves assume a certain amount of responsibility in the follow-up. They ordinarily require that a boy report to them once a week, and in this way they determine a boy's own response to his treatment program. They also take over the burden of any home situation which may need attention.

A special follow-up committee from the City Wide Boys' Workers Conference acts in the case of every boy who takes out a club membership in his treatment program. The chairman of this special follow-up committee meets weekly with our staff follow-up worker, and together they approve the club affiliation upon which the boy himself has decided. Together they provide for special supervision within each recreational center. A typical case is the following:

John L. decides that he wishes to become an active member of the South Street Settlement House. The chairman of the City Wide Boys' Workers Conference follow-up committee meets with our staff follow-up worker. Together they determine the reasonableness of the selection. The chairman then sends a letter to the worker at that settlement who has been designated to interest himself in court transfers, telling him of John's selection. The staff worker then sees that the boy meets the settlement-club leader, and from time to time checks on the behavior of the boy in his club membership.

The follow-up worker is known as a "representative of the City Wide Boys' Workers Conference," and as such he visits the neighborhood and settlement houses without any of the stigma that might attach to the visit of a court officer. He also inspires a more active interest on the part of the club leaders for each delinquent boy, because he is virtually the settlement worker's representative.

With the approach of warm weather, it became evident that the work could not be carried on in the city during the summer months. Fortunately, the Lincoln House of Boston turned

over to the department a number of cabins which were used only for a winter program, and the entire Citizenship Training Department was transferred for six weeks to this camp, fifteen miles outside of the city. The boys were taken out by bus each morning at 9 o'clock, and returned each evening at 5 o'clock. Approximately forty-five minutes were allowed for reaching the camp. The program consisted of one hour of discussion class, two hours of work by the boys in the improvement of the camp, one hour for lunch, and an afternoon devoted to recreational activity. This set-up naturally permitted an elaboration of the general plan, and much more was accomplished in the way of treatment. There was sufficient work and discipline in the program to avoid the general impression that delinquency brought the premium of a camp experience.

## CONCLUSION

We have outlined an experiment designed to define and carry out an effective treatment program for delinquent boys on probation. It is a program dictated by the compelling observation that *group* therapy must be instituted along with individual treatment if society is to assume more than a mere custodial supervision of the great majority of youthful delinquents, who do not need the prolonged study and psychiatric treatment of the occasional mental deviate who breaks the law. The functions of this program are, first, to appraise the boy and his problem; second, to give each boy a preparatory experience in treatment to make him ready for the long-term program of therapy; and third, to make intelligent use of the treatment resources of the city by transferring each boy to that agency which is best equipped to carry on the long-term program of rehabilitation that is, in our judgment, best suited to meet his individual needs. In order to carry out adequately the purposes of the plan, it has been found necessary to combine two allied techniques in what may be termed a group-clinic approach to delinquency.

# GROUP AUTONOMY IN A CHILDREN'S INSTITUTION*

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THE Wayne County Training School is designed for the training of high-grade mentally defective children, most of whom are delinquent as well. It is limited to the higher-grade mental defectives, idiots and imbeciles being excluded and, as far as possible, those cases that will in all probability be permanently in need of custody. The average I.Q. of the population is 66. The emphasis in the entire program of the institution is upon training the children so that they may be restored to the community and, with the aid of a certain amount of external support from an active social-service program, make a reasonably satisfactory adjustment there. The school is interested not merely in giving its children good physical care or in training them for an institutional existence, but more particularly in developing a program of training that will make possible their return to community life.

As an experiment in training these children for social adjustment in the community, the superintendent of the school, Dr. Haskell, in June, 1935, established the Homestead Cottage. This cottage was to be an experiment in self-determined activity. The cottage building is located about half a mile from the other cottage buildings and is on the opposite side of the road that forms the institution "boundary" for the other children. Thus the boys in this group are separated from the rest of the institution geographically as well as psychologically.

The thirty-four boys who live in the cottage are selected on the basis of their behavior in the institution—*i.e.*, this is an honor cottage and admittance is a reward for successful adjustment to the program of the institution. The administrator sends to the cottage a list of eligible boys from which the boys

* Read in the Clinical Section of the American Psychological Association, Minneapolis, Minnesota, September 2, 1937.

in the cottage elect those whom they want. Thus there is a selection not only on the basis of merit, but, through the election by the boys, on the basis of congeniality with the rest of the group. This makes for a closely knit social group. In the two years since the establishment of the cottage, seventy-one boys have been enrolled in this group.

The group thus selected is composed of the older boys in the institution, the age range being 15 to 24 years, the mean 17.1 years. In I.Q. these boys range from 51 to 81, the mean being 65, one point lower than the mean of the entire institutional population. We thus have a group selected on the basis of conduct and composed of the older boys, but of approximately the same intelligence level as the school population.

This group is permitted almost complete self-determination. The boys handle their own discipline problems. Once a week they have a cottage meeting in which they discuss any infractions of the cottage rules—which have been enacted by the boys with the approval of the administration of the institution—and decide upon the proper treatment of offenders. All matters of discipline and cottage operation are left to the group itself, though the administration retains the power of veto in case the broader aims of the institution should be lost sight of in any specific case.

Since this is an honor cottage, the boys have certain privileges which those in the other cottages do not have. Thus they are allowed to go anywhere within the 1,000 acres of the training-school property instead of being limited to the cottage area; they may go in small groups (up to five) to the neighboring town to moving pictures without being accompanied by an attendant; and they may smoke in the cottage club rooms. Discipline takes the form almost entirely of withdrawal of these privileges for a period of time, although in certain very difficult cases the offender may be voted out of the cottage by the boys and returned to a less privileged cottage. There are no novel or spectacular punishments involving great personal inconvenience—marching, being made to sit in a chair for a certain period, and so forth—such as are commonly found in self-governing groups. There is no corporal punishment in the institution.

By far the most potent disciplinary force with these boys is group disapproval. The selection of new members by the group itself results in strong ties between the boys which make social approval an unusually strong motive with them. Group disapproval is expressed formally when an offender stands before the group and is publicly accused; but it is often expressed also in an informal way when, without suggestion or definite planning, the group merely withdraws from an individual and leaves him socially isolated.

Illustrative of this type of discipline is the incident of John, who worked in the cottage kitchen and who went for a walk one morning and did not return in time to prepare the noon meal. The boys came in at noon and found that there was no food. There was, of course, a great deal of concern and much condemnation of John. When the food finally came, the boys were thoroughly angry. The result was that without any discussion or planning, for the rest of the day no one spoke to John; he was not invited to participate in any activity, and when he came up to a group who were engaged in something, it melted away and left him alone. Since this incident, John has never taken an unauthorized vacation from the kitchen.

It is difficult to describe adequately the force of this group disapproval. These boys are constantly striving to increase their popularity with the group and thus any withdrawal of acceptance by the group becomes very important to the individual concerned. It can be truly said that the punishment itself is not important; what is important is the fact that by means of the punishment the group has expressed its disapproval of the individual. To many children of the type treated at the training school, a realization of the desirability of fitting into a social group is probably something relatively new.

The cottage is staffed by a cottage supervisor and a cook who supervises the cooking, although the work in the kitchen is done by the boys. The supervisor does not handle any discipline except by indirection. He fulfills more nearly the position of a counselor to whom the boys come with their problems. The supervisor is thus relieved of much routine work in connection with discipline and the conduct of the cottage and so has more time for the planning of activities

and constructive programs which is his chief function. At night and during the day when the supervisor is off duty, the boys take care of their own affairs without supervision.

The result of this experiment, we feel, is a group that is demonstrating its ability to manage its own affairs. Fewer difficulties arise in this cottage than in any other on the grounds. More projects of a constructive nature are spontaneously initiated by the boys here than in any other cottage. Through being allowed to deal with their own affairs, the boys are learning the inconveniences that arise from misbehavior and are appreciating the "why" of rules and regulations as few of them have ever done before. We feel that they are learning to appreciate the fact that it is more comfortable to live under a regulated social system than under a system in which every one does as he pleases, and through this are learning the necessity for social conformity. We can say without hesitation that this group has never committed, in their own cottage or elsewhere on the grounds or on any of their almost daily absences from the grounds, any breach of acceptable adolescent behavior.

Illustrative of the possibilities offered by a program such as this is the case of Alfred. Alfred was committed to the Wayne County Training School in 1933 at the age of twelve, because of behavior difficulties in school and because he was unable to adjust in boarding homes. His initial adjustment at the training school was not good. He was described as argumentative, quarrelsome, mischievous, bullying, overactive, and sullen. He resented authority and correction. His difficulties included fighting, picking on smaller and duller children, refusal to do cottage work, defiance of attendants when disciplined, truancy from the institution, and extreme profanity. He was unable to adjust to the routine of the institution or to any cottage in which he was placed. A rather extended program of psychotherapy proved unsuccessful, and attempts to interest the child or to capture his imagination failed. All attempts to adjust this child to the training school were unsuccessful.

In November of 1936, as a last resort, this boy was transferred to the Homestead Cottage, as an experiment. The experimental nature of the project was presented to the boys

of the cottage and they were asked if they would not accept him provisionally in order that we might see whether he could become adjusted in such a situation. This they agreed to do, and Alfred was accordingly sent to the cottage.

His initial reaction was similar to his reaction in previous cottage placements. He was given punishment by the boys for failure to do his cottage work, for smoking unlawfully, and for refusing to get up in the morning. His reaction to this was that the boys were "picking on him." He became sullen and defied the boys to make him serve his punishment. He soon saw, however, that such behavior did not cause any excitement in this cottage, but that he was only brought up again in meeting for these actions and given further punishment. No one was interested in forcing him; the group was content merely to express their disapproval and to take the outcome for granted. Thus his defiance did not gain for him any marked attention. In several long talks with him the supervisor adopted the same attitude; the desirability of conformity was pointed out to him without any attempt at forcing him to conform. Group ostracism was slow in producing its usual effect. The boys were puzzled by his solitary failure to respond, but their morale was sufficiently well grounded not to be affected by it.

Early in April Alfred began to strike up a closer individual acquaintanceship with another boy in the cottage, Mike. This acquaintanceship was originally colored by a fiction of belligerency. Mike's daily chore was the cleaning of a certain room, and when his job was done, he would make a great show of keeping every one out of the cleaned room. Alfred began coming into this room as soon as Mike had finished, and inevitably a "rough-house" would result, although each boy was very careful not to hurt the other. This gave Alfred a chance to try out social contacts, and at the same time permitted him ostensibly to preserve his old pose of nonconformity, since on the surface he appeared to be disturbing Mike, whereas actually for both boys the fighting was nothing but a game. This activity, because it was noisy and showy, always drew a crowd, and gradually other boys were enlisted on one side or the other of the jangle. Thus Alfred was drawn into acceptable prominence in a group situation that brought with

it the satisfaction of group acceptance and the realization of the fun that may be had only when one is coöperating with a group.

From this Alfred progressed to an interest in the activities undertaken by the cottage as a group. At first he was interested only in the rougher games, in which he could still, in his own mind, keep up a pretense of nonconformity. Gradually, however, he became interested in all the activities of the group.

Alfred now began to bid for popularity with the group. He became one of the most coöperative boys in the cottage and was willing to help any one at any time. The boys responded to this by accepting him. He became one of the most popular boys in the cottage and finally was elected chairman of the group. In this office he has handled the affairs of the cottage very well and has been an enthusiastic leader in all cottage activities. Our last report from Alfred was the remark, "Now I see how much trouble I caused when I was bad because, as chairman, I see how much trouble the other boys cause me when they are bad."

It is our opinion that such a result could not have been achieved in this case in a cottage operated in the usual way. We feel that it was achieved through showing the boy that nonconformity does not bring extra attention, but merely isolation from the group. In the usual cottage situation something must be done specifically about each misbehavior of which the cottage administration chooses to make an issue, and the punishment must be carried out; otherwise the attendant cannot "save his face." This sets the boy off as opposing the attendant and thus the institution in general, and too often the boy carries the group with him. In the Homestead, the problem is the group's problem, not the supervisor's; thus the boy opposes the group, not the supervisor. This can result only in group disapproval of misbehavior. Furthermore, the boy is allowed to bridge the gap between nonconformity and conformity in his own way, and thus can do so in such a manner that he does not have to admit his defeat in the process, but can maintain his self-respect in his own eyes throughout.

# SOCIAL FACTORS IN THE CASE HISTORIES OF ONE HUNDRED UNDERPRIVILEGED HOMOSEXUALS

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IN January, 1937, there was published a preliminary report of a study of one hundred homosexuals, socially well adjusted and coming from the professional and leisure classes.[1] The project was one of those sponsored by the Committee for the Study of Sex Variants.[2] The present paper may be regarded as a continuation of the committee's study of homosexuality.[3]

The investigation of the socially and economically adequate group was continually bringing to light cases of men in depressed social and economic situations, some of them with criminal histories. So frequent were these cases that it was deemed advisable to undertake an investigation into this underprivileged group, with the idea that the data secured would be of value not only in themselves, but for purposes of

[1] "Psychogenic Factors in Overt Homosexuality," by George W. Henry, M.D. *American Journal of Psychiatry*, vol. 93, pp. 889–908, January, 1937.

[2] The Committee for the Study of Sex Variants is a research group formed in 1935 under the chairmanship of Dr. Eugen Kahn, of the Department of Psychiatry of Yale University, with the aim of correlating and furthering activities in this field of study. It is interested in any research project that has a bearing upon the physiological, psychological, psychiatric, or sociological problems of sex variants.

[3] It was not possible to secure much data in relation to underprivileged lesbians because of the paucity of material in the official files. Lesbianism is a phenomenon less well known to the lay public, and there is not the same reprobation of it as there is of homosexuality among men. Furthermore, it is better concealed from the public eye. Hence police activity against it is negligible. Only two opportunities for getting into contact with lesbians presented themselves in the course of the investigation. In both cases, the subjects were middle-aged women who derived part of their income from more conventional prostitution. They lived on the fringe of a homosexual group.

comparison with the more economically secure homosexuals and for the light they might throw upon the study of the criminal sex offender and upon the more general study of personality distortions. Unlike the socially adequate group, the men reported on here did not voluntarily offer themselves for study.

Of the hundred men included in the study, the histories of 68, or roughly two-thirds, were available in the probation records of the Court of General Sessions and of the City Magistrates' Court of the City of New York. Permission to study these records was generously granted by the court authorities, to whom we are indebted for this aid in an investigation undertaken with the hope of facilitating the handling of an important human problem. Naturally the authorities insisted that we take every precaution to protect the identities of the men studied, and this was done. Assumed names were arbitrarily given to these men in order to conceal their identities even from ourselves.

With the remaining 32 of the group, contacts were made by a research assistant in public places as opportunity offered. These contacts were never, of course, completely satisfactory because of their casual nature. Men had to be interviewed where they were found—on subway trains and stations, on park benches, in public squares, along the water front, in low-grade homosexual resorts, restaurants, tea rooms, cafeterias, barrooms, and in one case a public comfort station. In the face of these difficulties, fragments were gathered here and there, to be fitted together laboriously at a later date. Out of these fragments a mosaic of the underprivileged homosexual began to take form.

A further handicap arose out of the inadvisability of acquainting the subjects with the fact that they were being interviewed for a purpose. This automatically prevented the field worker from undertaking any but the most cautious questioning. Men in this social situation do not respond to an appeal for coöperation in a scientific undertaking. They are suspicious of an inquiry that may have police significance. The necessity for precautions in dealing with them became evident as the investigation proceeded.

## II.

In the state of New York there are two categories of crime—felony and misdemeanor. A felony is a grave crime, which may be punished by imprisonment in state's prison, or, in the case of murder, by the infliction of the death penalty. A misdemeanor is a crime deemed by the law to be of less gravity; it is punishable by the imposition of a fine or a comparatively brief penitentiary or workhouse sentence. In cases both of felony and of misdemeanor, the court may suspend the execution of the jail sentence and remand the defendant to the supervision of a probation officer.

Sodomy, legally defined as carnal knowledge by the anus or by the mouth, is a felony, punishable by imprisonment in state's prison. After trial and sentence in the Court of General Sessions, when a man has been convicted by a jury, or when his plea of guilty has been accepted, he is remanded for investigation by the probation bureau of the court. There an exhaustive social investigation of his whole career is made, and the report of that investigation is available to the judge to aid him in his consideration of the sentence to be imposed. This social investigation may include a psychiatric examination, and the court has a well-equipped psychiatric clinic with an able staff.

Other cases involving homosexual practice are tried by the Magistrates' Courts under the name of disorderly conduct. The Magistrates' Court is the criminal court of first instance in the city of New York. Where, in a case involving homosexuality, the sitting magistrate deems it wise to refer the case for prosecution to the higher courts, the defendant is held for the action of the grand jury, which may or may not indict for sodomy. Otherwise the case is handled as a misdemeanor, and the magistrate himself takes jurisdiction, hearing the case immediately, or granting an adjournment in order that counsel and possible witnesses may be arranged for. The law sets up adequate machinery for appeals from the determination of the magistrate. Unfortunately there is no adequate provision for counsel for indigent defendants, and because of the tremendous volume of cases coming before the magistrates, there is always the possibility of an occasional miscarriage of justice.

The composition of the group of criminal homosexuals studied was as follows:

| | |
|---|---|
| Men convicted of sodomy in the Court of General Sessions..... | 14 |
| Men convicted of (homosexual) disorderly conduct in the City Magistrates' Court..... | 52 |
| Men convicted of disorderly conduct (sex offenses involving the annoying of children) in Magistrates' Court..... | 2 |
| Total..... | 68 |

The cases were taken in order as they turned up in the files for 1935. In the Court of General Sessions, Mr. Irving W. Halpern, the chief probation officer, gave us the records of the sodomy convictions for the past year. Mr. Patrick J. Shelley, the chief probation officer in the Magistrates' Court, adopted the same procedure for the homosexuals who had been investigated by its probation bureau.

## III.

The Court of General Sessions offered a greater wealth of factual material regarding the men studied. This is due to the fact that in General Sessions the probation officers are more adequately trained and their case load is smaller. Moreover, the criminal situation is much more serious in that court, and much more comprehensive studies of offenders are required. The magistrates deal with misdemeanants in great numbers, their jurisdiction is limited, and their probation officers have neither the time nor the equipment for undertaking adequate studies of the men under investigation. In view of these handicaps—and the surprisingly good case-work that is done in spite of them—it is no reflection on the lower court to say that the best prepared material for case studies comes from the General-Sessions probation bureau. The probation records in General Sessions were complete, amply documented social analyses of what Mr. Halpern has well described as "tenement-house sodomies."

All but two of the cases in the Magistrate's Court had to do with sex conduct between adults; in the Court of General Sessions children were involved, the fourteen men studied there having been convicted of the crime of sodomy upon the person of a child from six to sixteen years of age. Theirs were stories

of limitation—social, economic, educational—such as are found among other underprivileged groups.

These sex offenders have been described elsewhere as follows:

> "Invariably these men were found to come from recent immigrant stock. They were themselves immigrants or the children of immigrants. They came from homes which were broken through the withdrawal of one or both parents in early childhood. They came from depressed districts. Some were reared in institutions. Their formal education was meager, the scholastic maximum, with one or two exceptions, being the eighth grade. They had no regular trades, but worked at indifferent jobs for low wages. There was no regularity in their industrial history. They made no constructive use of their overabundance of leisure. The cheap movie, the pool room, the street-corner gang, and the underworld enterprisings furnish the boundaries of the sex offender's social life."

The data on these fourteen cases of sodomy may be summarized briefly as follows:

*Age.*—Contrary to the general picture of criminality nowadays, these men were not an especially youthful group. They ranged in age from sixteen to sixty-nine years, 8 of the 14 being over thirty. In other words, they were a comparatively elderly group. Specifically, the age grouping was as follows: 3 were between sixteen and twenty years old, and 3 between twenty-one and thirty; 4 were between thirty-one and forty, and 4 over forty-one.

*Marital Status.*—Eleven were single and 3 married, one of the latter being a widower and another divorced or separated.

*Race.*—Ten were white, and 4 colored.

*Nativity.*—Nine had been born in the United States, 5 elsewhere, 2 of the 4 colored men having come from the West Indies. Of the fathers and mothers, 6 each had been born in the United States.

*Home Situation.*—In 9 cases, including one reared in an institution, the father had died during the boy's childhood, and in 3 other cases the mother had died. In the two remaining cases, information on this point was not available.

*Religion.*—Eight of the men were Catholics; 5, including the 4 colored men, were Protestants; and one was Jewish.

*Living Quarters.*—Eight of the men came from tenements and 4 from rooming houses. Of the 2 remaining cases, the

living quarters were classed as medium in one and as superior in the other.

*Education.*—Twelve of the men had not gone farther than the eighth grade. Two were in high school.

*Occupational History.*—Two of the subjects were still in school. Of the others, 11 were laborers and one was in domestic service. The longest period during which a job had been held was as follows for these 12 cases:

| | |
|---|---|
| Not over 3 months | 6 |
| 6 months to 1 year | 1 |
| 1 to 5 years | 1 |
| Over 5 years | 4 |

The weekly wage levels attained were:

| | |
|---|---|
| Not over $10 | 3 |
| $11 to $15 | 6 |
| $16 to $20 | 1 |
| $21 to $25 | 1 |
| $26 or over | 1 |

*Previous Conflicts with the Law.*—Eight cases had previous criminal records and one a history of juvenile delinquency. In the other 5, there was no record of previous conflicts with the law.

*Mental Condition.*—In practically all of the cases, the men had been given a psychiatric examination. In only one case was there a suggestion of a possible psychosis. In intelligence they ranged from dull normal to average, with the exception of one high-grade moron. Otherwise they were neither psychotic nor feebleminded.

## IV.

The men studied in the probation bureau of the Magistrates' Court were clear-cut cases of homosexuality. They had been arrested in subway toilets, cheap moving-picture theaters, and other places in which disorderly conduct is found. Approximately four times as many offenders were studied here as in the higher court—52, with the exclusion of two men convicted of annoying children.

The main facts in the case histories of these 52 men were as follows:

*Age.*—They formed a more youthful group than the men studied in General Sessions. As in the General-Sessions cases, the age range was from sixteen to sixty-nine; but there were 5 offenders under twenty, and only one was over fifty. Twelve were between thirty-one and forty, and 10 between forty-one and forty-five; one was forty-seven. The greatest number, 23, were between twenty-one and thirty.

*Marital Status.*—Forty were single and 12 married, of whom 2 were widowed and 3 divorced.

*Race.*—Thirty-six were white and 16 colored.

*Nativity.*—There was a decided variation from the popular picture of criminals in general in that these offenders did not quite so often appear to be foreign born or of second-generation immigrant stock. Of the 52, 36 were born in the United States, 26 of them of native-born parents. Of the 16 colored men, 4 came from the British West Indies and one from the Dutch East Indies.

*Home Situation.*—The broken-home situation also appears less prominently in this group of cases. Thirty-one of the men had lost a parent in childhood, the father in 26 cases, the mother in 5; in 19 cases, both parents were still living. Only two men were reported as having had institutional upbringing, no information being given as to what circumstances—death or desertion of parent and so forth—had brought the institution into the picture.

*Religion.*—Twenty-two of the men were Catholics; 25, including the 16 colored men, were Protestants; and 5 were Jewish.

*Living Quarters.*—The data on the living quarters of these men were significant. Twenty- three were reported as coming from tenements, where they either lived with their families or boarded or were connected in some other way—no matter how loosely—with a family group. Sixteen came from rooming houses, where they lived either alone or with a "friend." Of the 13 reported as coming from medium or superior social situations, only one resided with his family, the other 12 living either alone—in one case in the dormitory of a graduate school—or with other homosexuals.

*Education.*—Twenty-eight of the men had not gone farther than the eighth grade. Twelve had gone into eighth grade or

high school. Of the remaining 12, 4 had graduated from high school, 4 had gone to college, and 4 had attended a graduate or professional school.

*Occupational History.*—Twenty-seven of the men reported themselves as laborers. Five were in clerical work, and 7 in domestic service. There were 3 actors—2 of them female impersonators—and 2 clergymen. Two were "singing waiters"; one was an orderly; and one a church organist.

Data as to the longest period during which a job had been held were as follows for this group:

| | |
|---|---|
| Not over 3 months | 13 |
| 3 to 6 months | 5 |
| 6 months to 1 year | 9 |
| 1 to 5 years | 12 |
| Over 5 years | 12 |
| Information refused | 1 |

The weekly wage levels reported were:

| | |
|---|---|
| Not over $10.00 | 7 |
| $11.00 to $15.00 | 20 |
| $16.00 to $20.00 | 10 |
| $21.00 to $25.00 | 9 |
| $26.00 or over | 6 |

The maximum weekly wage reported was $36.00.

*Previous Conflict with the Law.*—Nineteen of the men had previous criminal records and there was one record of juvenile delinquency. In the remaining 32 cases, there were no records of previous conflicts with the law.

We find here the same general picture as that observed in the Court of General Sessions. There are greater variations, because of the greater size of the group, but no change is to be noted in the general outline. The chief difference between the groups is a difference of degree of conflict with the law. In as much as the higher court deals with felony cases, the men studied there turned out to be seasoned offenders, most of them with long criminal records, in which sex offense was not the chief charge. Their criminal histories included burglary, assault, robbery with violence, alcoholism and drug addiction. Of the men in the Magistrates' Courts, on the other hand, 32 had no previous criminal records. One had a record for juvenile delinquency only. The remaining 19 had come into conflict with the law, some of them repeatedly, because of

their homosexual promiscuity. Only 4 had records that involved other types of crime.

It was a group as clearly marked by limitation as that in the Court of General Sessions, although a few of the men came from favorable social situations. These showed every sign of deterioration. In one case, in which the case record was well prepared, there was a long history of decline in earning power, from regular employment at $36 a week down to an industrial level of odd jobs averaging $10 or less weekly.

A probation officer called attention to the apparent effect of the homosexual pattern upon an offender's economic adjustment. The case in question was that of a man with six arrests growing out of homosexuality. The probation officer suggested a certain correspondence between this career and that of a drug addict. "It looks," he said, "as if the poor devil's 'habit' had gotten such a hold on him that he couldn't keep a job." Everything else had become subordinated to the individual's homosexual needs.

The magistrates themselves dislike dealing with these cases. When they are treated as routine matters, the offenders are given small fines or placed on probation on their first offense. Some judges, for one reason or another, impose jail sentences on all homosexuals, even in the case of first offenders. As these men come before the courts again and again, the term of imprisonment is lengthened until they receive the maximum penalty, although neither imprisonment nor the threat of imprisonment produces any change in the offender's mode of living; at most it serves to make him more cautious. The probation officers, when they receive men for a period of probation, undertake to supervise the offenders' industrial activities wherever possible, and try to keep them from making further homosexual contacts. Therapy other than this is practically never attempted.

In one case, Magistrate Kross undertook an experiment in therapy in the case of an individual who seemed suitable for such treatment. She placed him in the joint care of the probation bureau and the Bellevue Hospital Psychiatric Department. He was seen at the psychiatric clinic at regular intervals for a year, apparently with beneficial results. He was discharged from probation with improvement noted. The

apparent success of Magistrate Kross's experiment should be an encouragement to its repetition, certainly in cases in which the individual seems likely to derive benefit from therapy.

No interviews could be arranged with these men. The incidents of life among underprivileged homosexuals were secured in interviews with the men with whom contact was made in public places.

## V.

The interviewing of homosexuals in public places—the third phase of the study—was the most difficult because homosexuals are suspicious of anything that resembles an inquiry into their personal affairs. An investigator armed with a notebook would draw a complete blank. In order to make contact with these men, it was thought best for a field worker to appear, roughly dressed, in places in which homosexuals were known to congregate. The investigator undertook to create by indirection the impression that he was an idler with a good bit of worldly knowledge. The subject was engaged in conversation until with little or no guiding he would begin to talk of himself. In only two cases was the investigator suspected of ulterior motives. In one case an unkempt young man, who was dressed in rags, but who had very evidently attended a university graduate school, wanted to know if the investigator were collecting material for a doctor's thesis. He was sure that he had no information to offer, and equally sure that he could use a dime. In the other case, the investigator was accused of being a plain-clothes policeman or an informer. It was possible to reassure this man of the honesty of the investigator's intentions, so far as the police were concerned, and in the end a very satisfactory interview was secured.

Not all of these interviews were satisfactory. Notes could not be taken on the spot, and in some cases they would have proven worthless, even if they had been taken. Contacts had to be made with about eighty men to get 32 interview records that had enough data in them to work with. It was, of course, impossible to check any of the data given, save in so far as a homosexual confirmed some detail in the story of an acquaintance.

A summary of the data as given by the men interviewed is as follows:

*Age.*—The ages of the men ranged from sixteen to forty-three. Three were between sixteen and twenty years of age; 20 were between twenty-one and thirty, 7 between thirty-one and forty, and 2 between forty-one and forty-three.

*Marital Status.*—Thirty of the men were single. Of the 2 who had married, one was widowed and one separated from his wife.

*Race.*—Twenty-nine were white. Of the 3 colored men, one was a mulatto.

*Nativity.*—Twenty-six of the men reported that they had been born in the United States and 2 elsewhere; in 4 cases, information on this point was not secured. The nativity of parents was given as the United States in 20 cases and as elsewhere in 8 cases; 4 did not supply information on this point.

*Home Situation.*—Fifteen men reported the death of their parents during their infancy. In 3 cases, the parents were still living. No data on this point were secured from the other 14.

*Religion.*—Sixteen of the group were Catholics; 8, including 2 of the negroes, were Protestants; 6 were Jewish; and 2 reported themselves as atheists. One of the latter was a Negro; the other was a former Catholic.

*Living Quarters.*—Eight men were living in tenements and 13 in rooming houses; 6 were homeless. In 3 of the 5 remaining cases, the living quarters were classed as medium and in 2 as superior.

*Education.*—Fourteen of the men had not gone beyond the eighth grade. Ten had attended high school and 6 others had gone to college, but had not taken their degrees. One had graduated from college and another from a divinity school.

*Occupational History.*—Eight men were laborers and one was in domestic service. Nine were clerical workers (one of them, though he gave clerical work as his gainful occupation, regarded himself as a poet). Five reported themselves as professional men, one of them a clergyman. Three were "hoboes," and 3 others stated that they subsisted by crime. In the remaining 4 cases, information as to occupation was not secured. Seventeen of the men reported themselves as em-

ployed and 15 as unemployed. No data as to duration of jobs or weekly wage levels were available.

*Previous Conflicts with the Law.*—Five men admitted to prison experience. This figure is doubtless too low.

These data amply duplicate the picture of social limitation previously observed. They show, moreover, two types of limitation—limitation from birth and limitation as a result of deterioration, both of which have been noted in connection with other criminal groups. Two examples of the social deterioration associated with homosexuality are given later.

These histories, however, differ from the usual criminal history in one point. As in the case of the homosexuals studied in the Magistrates' Court, the factor of immigrant or second-generation-immigrant origin is not constant. In this group we find a new element—that of native whites, of native parentage, economically limited, who have drifted to New York. Some of these poor whites had come from rural districts, as young heterosexuals do, to seek their fortunes. Some had come because they had got into scrapes at home. Most of them, however, had come because their local communities frowned upon homosexuality, and New York seems to be the capital of the American homosexual world. At all events they had heard, or had imagined, that the lot of the homosexual would not be unbearably hard in New York. Of this group, many had been able to find work, a homosexual circle of acquaintance, a definite social life, and therefore adjustment of a sort. Some had found a protector, and therefore financial security and temporary adjustment of another sort. Some, less fortunate, had been unable to find work, but had been lucky enough to find a certain minimal economic security in home relief. Others, defeated in their hope of economic self-sufficiency, had resorted to begging, male prostitution, theft, and other petty crime. A few had found solace in drink and drugs.

## VI.

Like every other world, the homosexual universe is divided into strata, perhaps the most important line of demarcation being that of social and economic situation. It is not, however, a line that is hard and fast. Even without good looks, it is possible to have a lucrative career for a while in the

homosexual world. One may cross over from the underprivileged to the economically secure group at any time one finds a job or a friend. Nor can one say that the pathways of the two groups never cross. A young hoodlum homosexual may have acquaintances among some very superior people, and homosexuals of assured social position have been known to have some very dubious friends. The four brief case notes given below indicate the ease with which social boundaries may be crossed and throw light on the social deterioration among homosexuals.

1. Francis Brown[1] is a home-relief client. He is a native American, aged thirty, of good middle-class background. After finishing high school, he went to work and became economically self-sufficient, making a place for himself as a laboratory technician. For a time he was employed to take the histories of incoming patients in a New England hospital. He found extra employment out of hours by doing some medical photography and making sketches for the physicians under whom he worked. In addition, he was happy enough there to take on some volunteer work in the hospital social-service department. He was dismissed by the hospital authorities because of his homosexual difficulties. His jobs thereafter were briefer and more poorly paid, with long periods of idleness intervening. He gravitated to the W.P.A., and secured work as an artist's model, but even that job disappeared in one of the periodic W.P.A. shake-ups. Hitherto he had moved in a circle of reasonably secure white-collar homosexuals, and had been accepted by them as an equal, but with each step in his economic decline, friends dropped away, and he descended from lower to still lower grades of homosexual society. Now he supplements his scanty home-relief allowance by frequenting the lowest of homosexual resorts and public places in the hope of gain through prostitution. He deliberately dresses and acts so as to call attention to his obvious homosexualty.

2. Stanislaus Prystalski is a Polish-American Catholic, of lower-middle-class origin, who started out in life to be educated for the priesthood, but fell by the wayside, feeling that he had no aptitude for the ministry. His first homosexual experiences were with young men of his own class. During adolescence, he was extremely attractive to older men of means, by whom he was introduced into socially acceptable homes. Thus far his career has been on the upgrade. He has been given week-ends at Southampton and Newport and is not unacquainted with life in Park Avenue penthouses. At present he is nominally secretary to some sort of literary person. This man regards Stanislaus as a member of his household and has taken him twice on trips to Europe. Stanislaus has Americanized his name, and now, in his twenty-fifth year, lives an untroubled and apparently contented life as a male mistress to his patron. His only fear is that he may lose his good looks.

3. Pat Duffy, an Irish-American, comes of Iowa farming stock. His parents died in his infancy, and he was brought up in the home of a

[1] All the names used in these case histories are fictitious.

relative, a bishop of his church. His childhood and youth were apparently normal, considering the factors of the broken home and the formidable episcopal relative, who seems to have interested himself but mildly in Pat's upbringing, leaving him to the care of two aunts. Pat insists on the normality of his childhood in the farming country, with its country grade school and high school and a considerable variety of playmates of both sexes. He did not at that time become conscious of homosexuality and he denies early homosexual experimentation. He went to the University of Chicago and the Chicago Art Institute, and there fell into the hands of homosexuals and radicals. Pat has been an itinerant worker and a radical agitator in a small way. He has beaten his way to the Pacific Coast, and knows his way among Western radicals and homosexuals. He has taken up Communism, despite the fact that official Communism frowns upon homosexuals. Now he works at a menial job in a cheap cafeteria to economize so that he may spend his money on Communism and the young hoodlums he momentarily admires. He is twenty-eight years old, and has absolutely no desire to return to a more normal world. He says that he has abandoned both religion and respectability.

4. There is no need to disguise "Heavy's" name—we never learned it. He is a Southern white, about twenty-eight years of age, who came to New York because he said that there were no opportunities at home for him to work at his trade as a butcher. He found no work in New York, and became part of a group of young hoodlums who infest Central Park in the summer time. He had been reduced to begging and to petty crime in order to live. There is no doubt that he indulged in male prostitution. He was not signally successful thereat, however, because, despite his six feet and over two hundred pounds, his phallus was very small. Homosexuals seem to have a preference for large sex organs, so "Heavy" had hard sledding for a while. He was befriended for a while by the proprietor of a restaurant which is a homosexual rendezvous in a discreet way. "Heavy" finally managed to find a patron to whom he was sexually satisfying. He left the restaurant keeper $15 poorer. He is now reported by one of his friends to be living in luxury in a Miami hotel, and cutting quite a figure in the Miami *haute monde* of gamblers, racketeers, and racetrack figures.

In this transition from stratum to stratum, we see something that bears a surface resemblance to democracy. There seems to be less prejudice in this group against Negroes, Jews, and foreigners than is observable in other sections of the population. One explanation of this tolerance may lie in the fact that the common bond of homosexuality cuts across prejudices held elsewhere. On the contrary, many homosexuals have violent racial, religious, national, and even sectional prejudices. For example, two men from the neighborhood of Boston exhibited violent prejudice against Southerners.

## VII.

Underprivileged homosexuals may be divided into three types—the orderly homosexual, the exhibitionistic fairy, and the hoodlum.

The orderly homosexual works, subsists on the contributions of friends or on home relief, and seeks companionship among his own kind, occasionally, but not too successfully, venturing outside his own circle for his social life. He must make some sort of compromise with the external world, and he constantly seeks to conceal his homosexuality from outsiders. These men seldom "let down their hair" to strangers, but do so in the company of those whom they feel they can trust.

These homosexuals are haunted by a constant fear of the police and the blackmailer. They must protect their small jobs or their tiny incomes at all costs, in order to safeguard themselves from the terrifying consequences of exposure. Every new individual is some one to be mistrusted, perhaps feared, unless he has been previously vouched for, or until he has demonstrated that he can be trusted. It is hard to say whether the homosexual of this type in the low-income group fears the police or the blackmailer more. Perhaps the blackmailer represents the worse terror. Arrest and imprisonment are shameful and disgraceful, but the threat of these, in a blackmailer's hands, is a sword of Damocles more apt to destroy its victim by the fear it inspires than by the actual destruction it can cause.

Yet, despite these fears, so great is the urge to homosexual expression that these men constantly take incredible risks in their search for new companionship. Man after man, on being interviewed, will report that it is the thrill of the chase, rather than the sex act itself, which so exigently drives him to taking unbelievable chances. Many have had hairbreadth escapes from the law or the blackmailer; they have been beaten and robbed; and yet they persist in exposing themselves to situations that seem dangerous beyond calculation. Almost every homosexual has a friend who either has been jailed—or at least has had a narrow escape from arrest—or has paid tribute to an extortionist. And this despite the fact that homosexuals are otherwise notoriously timid souls.

The exhibitionistic fairy cares little or nothing for the blackmailer, and he claims to care not much more for the police. Often he has nothing to lose. His jobs are few and far between. The extortionist has learned that the fairy offers extremely lean pickings most of the time, and so he confines himself to other game. Sometimes a fairy will permit himself to be used as a decoy for a blackmailer. He will maneuver a more masculine-looking homosexual into a compromising situation, and then the blackmailer will descend on the pair, posing as a detective to extort what he can.

The fairy's attitude toward the law is simple. It resembles that of a female prostitute. Arrest and imprisonment are to be avoided if possible, but a stay in jail, if it is not too lengthy, may afford considerable sexual gratification at the cost of minor discomfort. It is a sad commentary on our penal system that the advent of a homosexual in many of our prisons is welcomed as a godsend by many of the inmates.

Neither imprisonment nor the threat of imprisonment is of much consequence to the hoodlum homosexual. Most of them have records that include prison experiences. The hoodlum homosexual waxes wrathy if he is regarded as a homosexual. He claims that he accepts the proposals of other homosexuals only as a source of revenue, and that he derives absolutely no pleasure from such relationships. The conduct of one or two of the toughest customers interviewed belied their protestations. These men make prostitution their profession, or at least a professional avocation. As time goes on, they derive not a little gratification from the satisfactory performance of their professional duties.

So long as the hoodlum homosexual can exhibit to his public a rough, aggressive, "hard-boiled" exterior, he is quite content. He preserves his *amour propre* among his kind by loudly protesting his masculinity, and perhaps by boasting a little of the "fags" he has beaten and robbed. He seems to justify the fairies' description of him as "rough trade."

The earnings of the hoodlum homosexual are often supplemented by assault and robbery of clients or possible benefactors. The hoodlum knows a client fears to report his losses to the police, because he thinks that the police will look askance at a victim in the situation which made the robbery

easy. There is a persistent rumor to the effect that the police permit these hoodlums a bit of latitude in the way of robbery and assault in return for their services as informers or "stool pigeons." No foundation for this rumor has been discovered, although it is widely believed among those who put themselves in a position to be victimized.

Loyalties within this hoodlum element are not especially strong. The precarious conditions of life and the sharp competition for the wherewithal of existence serve in most cases to make each hoodlum regard every other as a possible enemy and one certainly to be outwitted. To judge by appearances, the gains from this mode of life are few.

The orderly and exhibitionist members of the homosexual underprivileged group are of interest to the police only as homosexuals and as nuisances; the hoodlum element are of interest as hoodlums and as a menace to society. Association with the hoodlum group is always a source of difficulty to members of the more orderly group. In one instance, it was unearthed that a fairy had been conducting a *liaison* with a hoodlum who had been accused by the police of the brutal murder of another benefactor. For days several of this fairy's friends lived in terror of police questioning and possible suspicion of complicity in the murder. They were quite sure that the questioning would be accompanied by torture—the dreaded "third degree." The hoodlum homosexual must be regarded as a member of the criminal class. Contact with him by other homosexuals automatically brings the weaker men into criminal antisocial groups. Some notorious gangsters are said to be homosexuals.

## VIII.

As the survey progressed, certain data about to be recorded were observed with sufficient regularity to be set down as characteristic of this underprivileged homosexual group. These phenomena are not necessarily confined to the underprivileged group; in some instances they are found among more economically secure homosexuals. They have, however, been observed repeatedly in this underprivileged group and are offered as characteristic of it.

1. There is, as we have said, no absolute stratification in the

group. A man may pass from one social level to another under pressure of circumstances. He may even pass from the underprivileged into the more economically secure group, and it is quite easy for him to gravitate from the superior to the inferior group. There are always a certain number of men in a state of social transition.

2. Homosexuals recognize each other intuitively as well as through experience. There are a certain number of homosexuals whose manner and appearance easily betray them, but the majority cannot easily be detected. Hoodlum homosexuals are perhaps the most difficult of detection.

3. The group has a special language of its own. For instance, the homosexual gives special homosexual meanings to words that have currency in ordinary speech and to words ordinarily regarded as slang or profanity. To illustrate, in England a female dog is a bitch and a lady can use the epithet without provoking elevation of eyebrows. In America, we are somewhat more refined. No lady would refer to a female dog as a bitch without blushing, saving, possibly, some of our more doggy ladies. "Son of a bitch" is profanity and a fighting word. In homosexual language, the range of meaning involved in the term bitch runs from an innocuous reference to an individual as a homosexual to the connotation of a fairy's pronounced exhibitionism. A "flaming bitch" is an individual very vivid in manner, dress, appearance, and conversation.

4. There have come to be more or less fixed meeting places where homosexuals may be reasonably sure of finding men similarly situated, and where they may share their specialized social life. These places become known to homosexuals by word of mouth. There is no particular effort at concealment, and it was quite possible, after confidence was established, to learn the names and locations of a number of places of this sort. They run from resorts more or less openly conducted to extremely discreet places whose existence is known to comparatively few. Most of them are eating and drinking places, some with entertainment features. An occasional Turkish-bath establishment and some summer seaside bathing pavilions cater to homosexuals.

5. The less well economically situated homosexuals are apt

to resort to subway toilets, public comfort stations, cheap moving-picture theaters, and other public gathering places such as dance halls, skating rinks, and certain restaurants and cafeterias, in the hope of finding sexual companionship.

6. These places are fairly well known to the police. They make an occasional arrest, but their efforts to stamp out this particular type of sex activity are futile.

7. Some of these places are equally well known to extortionists, who find in them a fair source of revenue. The orderly homosexuals who are employed—clerks, mechanics, interior decorators—make the choice victims. Some of the police believe that these men are easier to bleed than men in secure economic situations, because the latter have powerful friends who are capable of dealing with blackmailers.

8. The orderly homosexual is usually fearful of a new acquaintance. Each new face suggests a possible danger. When his fear is overcome, he will talk readily, up to a point.

9. Among themselves, homosexuals are loose tongued, and they delight in recounting amorous adventures. A choice topic seems to be the size of the sex organ of each new conquest. The larger the sex organ, the more desirable the conquest.

10. The sexual attachments of men in this group are of very brief duration. What is sometimes known as "marriage" between homosexuals rarely, if ever, occurs at this underprivileged level. Almost all of these people are quite promiscuous.

11. Venereal disease on this level is not uncommon. It should be noted that not a few of these men believe that it is possible to conduct sexual relations with other men without fear of venereal disease.

12. Lying and stealing are common among homosexuals on this social level.[1] They attribute low motives to each other in conversation, and seem always willing to belittle their friends.

[1] One homosexual who had undergone a great change of outlook said, "All bitches are liars." Lying and stealing are accepted social phenomena. Superior homosexuals more or less expect to be lied to and stolen from by those they befriend, and are agreeably surprised to find honesty. Homosexuals usually take their friends with the proverbial grain of salt. When they permit their friends to use their rooms or entertain them overnight, they lock up everything movable. One homosexual with a sense of humor said that he would trust another homosexual's statements as far as they could be verified, and then believe about half of that.

13. Most homosexuals in this group seem to regard sex crimes against children with varying degrees of abhorrence. The deterrent runs from expediency (fear that children are talkative) to a sentimental regard for the sacredness of childhood.

14. As a general thing, the members of this group are as socially conservative as their more favorably situated brethren—perhaps more so. Most of them are inclined toward religious conservatism. Not a few are quite devout in the performance of their religious observances.

15. The group is essentially youthful. There is a small number of middle-aged and elderly homosexuals who seem to be in perpetual quest of their youth, but the elderly homosexual is a phenomenon more likely to be encountered in the socially superior group. Among the underprivileged, he is barely tolerated, and that only for the favors his money can buy. What becomes of the elderly homosexual on this level is something of a mystery. Either he gravitates down to the Bowery level, or his difficulties become so acute that he ends in a mental hospital or a penal institution. In a few cases, senile or pre-senile homosexuals, realizing their inability to attract young men, attempt to commit sodomy or other sexual offenses upon children.

16. There is a certain social snobbery to be seen among homosexuals on this level. "Upstage" is an epithet frequently used to describe the somewhat more secure men who fear possible social stigma as a result of association with the declassed. Homosexual sensitivity being exceedingly acute, many men doubtless suffer from highly imaginary slights.

17. Despite the competition, the lying, the stealing, and the snobbery, there are observable signs of a certain camaraderie or solidarity among homosexuals. This solidarity in all probability has its basis in homosexuality.

18. Despite certain tendencies to conservatism, no common philosophy has been observed among homosexuals. They seem pretty well divided among themselves on the ordinary intellectual concerns, and even on the vital question of how society should deal with the problem of homosexuality. There are homosexual Catholics, Protestants, Jews, freethinkers, and atheists. There are homosexual Fascists, Communists,

Democrats, Republicans, anarchists. There are homosexuals who believe in evolution and homosexuals who think that evolution is an invention of the devil. There seems to be no authoritative homosexual *Weltanschauung.*

SUMMARY

1. Social and economic situation divides homosexuals into two grades—the "haves" and the "have nots."

2. In the underprivileged group, conflict, or the danger of conflict, with the law seems more pressing than among the secure. Economic pressure forces the insecure into a more public search for gratification of their sexual drives. This leads to association with other criminals.

3. This underprivileged group is handicapped by a poor biological start, inferior housing, limited education. Its vocational training is of the scantiest. Its members usually have difficulty in finding and keeping work.

4. Partly through its own demands and partly through external pressure, the group is forced into a world of its own. Police action, being punitive and therefore fearsome, increases emotional tension, which in turn means increased sexual tension. As fear increases, homosexuals probably seek haven in that world of their own, into which it is their tendency to retreat further and further. It is a world of insecurity, sometimes tolerated, more often sharply dealt with, by society. For many homosexuals, the business of living in the homosexual world and appearing to live in the external world becomes a burden too great to be borne, and they become social liabilities.

5. Thus far no effective medical, legal, or social means of dealing with the homosexual in an underprivileged social and economic situation has been discovered. Further study of the problems presented by this group is urgently indicated.

# THE RELATIONSHIP BETWEEN EDUCATION AND MENTAL HYGIENE *

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THE term mental hygiene is at present creating a considerable amount of conflict among the various people and agencies that profess an interest in the problems classifiable under that broad term. One wonders if the term was, after all, a very fortunate one, for its general vagueness may tend to discourage clear thinking. The confusion that now characterizes much of the thought and action connected with mental-hygiene programs results in large part from the fact that the present interest in and emphasis upon mental health have developed from many different sources.

There are at least seven relatively distinct and sometimes antagonistic sources of this interest in mental problems. These sources will be mentioned here in random fashion, with no attempt to indicate the order of their importance or of their historical appearance.

1. *Humane interest in improving the care and treatment of the mentally sick.* Individuals with this interest seldom or never raised questions as to the genesis of mental disorder. Their concern was with the pitiful case of the badly treated patient. One calls to mind the work of two eminent pioneers in this field, Dorothea Dix and Clifford Beers. Perhaps Mr. Beers has done more to promote what is called the mental-hygiene movement than any other single person. It is of vital interest in this connection to note that in his early writings and activities, chief emphasis [1] was laid upon the improve-

* Read before the Durham-Orange County Mental Hygiene Society, Chapel Hill, North Carolina.

[1] This is merely a statement of fact; it is in no sense a criticism. There is ample evidence in Mr. Beers's original book, long since a classic in this field, and even more evidence in his later writings, that from the beginning he envisioned a program of preventive mental hygiene. As Secretary of The National Committee for Mental Hygiene, and through other activities, he has had a significant part in promoting this positive program.

ment of the procedures involved in the commitment, care, and treatment of the mentally ill. This early emphasis was logical, and perhaps wise, but not a few people with less vision than Mr. Beers and his associates have tended to *limit* the meaning of mental hygiene to problems of this nature.

2. *The interest of the medical profession, including psychiatry.* Since the times of the Greeks, and perhaps before, the practicing physician has been faced with the problem of treating people of unbalanced mind. Only a few outstanding physicians seriously concerned themselves with the problem of mental disorder, as such, but inevitably mental cases came into the practice of the doctor. The sorry tale of how these sick people were maltreated by laymen and how they were not treated by the physicians has been too well and too often told to need repeating here. Then came the latter part of the nineteenth century and the first quarter of this century, bringing the great founders of the branch of medicine called psychiatry. Under their direction and influence, the diagnosis, care, and treatment of the mentally ill have been remarkably improved. But it is well to remember that, with relatively few exceptions, the basic concern of the medical profession has been in improving medical diagnosis and medical treatment. To them mental hygiene has been mainly the treatment of disease or disorder.

3. *The interest of the academic psychologist.* The psychologist studies the human mind, as such. Theoretically he has not been interested (as a psychologist) in whether many or few people became mentally ill, in how these sick people were treated, in whether they were good or bad for society; his task has been to study the human mind in order that he might understand it. His interest in mental hygiene has thus tended to be theoretical, although there have been some great psychologists who have upon occasion assumed the rôle of teacher of the public. One thinks immediately of William James, C. G. Jung, William McDougall, and others. But even these men, it seems, have often thought of mental hygiene as the avoidance of deviations.

4. *The interest of the sociologist.* Certainly social relationships are conditioned by the health or lack of health of the mind. Here we come very near to a positive interest in

health conditions and influences. And yet one cannot help being impressed with the fact that social work is usually conceived as work with pathological social conditions.

5. *The interest of the criminologist.* Closely related to the sociologist's interest is that of the criminologist and of those who are concerned with delinquency and other behavior problems. To such individuals mental hygiene suggests child-guidance clinics, psychiatric clinics, habit clinics, and so forth. Recently the president of an old and highly respected mental-hygiene society remarked that unless the society was able to establish a mental-hygiene clinic or a child-guidance clinic, there seemed to be relatively little point in having the organization. This comment vividly illustrates what mental hygiene means to that group.

6. *The interest of those who are concerned with values—namely, the philosophers.* The question of this group is a vital one: What is good? Or, more classically stated, What is the great good and how may it be attained? What, in final analysis, should and may one seek? These people are likely to be interested in the theoretical goals or ends of life, and not much concerned with the structures basic to behavior.

7. *The interest of the educator.* It is the task of the educator to build personality and character upon the foundation of original human nature, biological and psychological.

At present an attempt is being made to bring all these interests together into a unified attack upon the problems of mental function and hygiene. This attempt to focus the efforts of such varied approaches quite naturally results in conflicts and confusion. In my judgment this conflict is needless and wasteful. It can be avoided by a more careful examination of what each of us means when he speaks of mental hygiene or a mental-hygiene program. It is possible that the term does not at all adequately cover what some of us have in mind. I cannot at present understand how it can possibly cover what *all* of us mean and still retain sufficient accuracy to be useful. It has been used with such varying meanings and so frequently with reference to pathology that the positive phases of mental hygiene are constantly in danger of being neglected. My purpose in the remaining part of this paper is to state as

clearly and accurately as I can the educationist's point of view in respect to mental hygiene.

1. What is mental health? Mental health is a condition of the personality which results in a type of functioning that brings constructive happiness to the individual—that is, the individual lives his life in such a way that his behavior promotes his own happiness and well-being and the happiness and well-being of society. Thus conceived, mental health exists in every conceivable degree. There is, however, rather close agreement as to the behavior that is indicative of the well-integrated, harmoniously organized personality, and the behavior that is indicative of the personality that functions badly.

2. A program of mental hygiene, then, includes everything that can be done to produce minds that guarantee this high quality of living. In short, a program of mental hygiene concerns itself with the production and maintenance of personalities that are healthy and effective. The purpose of the program is to produce personalities that, when mature, are capable of self-direction and self-repair under all reasonable conditions. The existence of some individuals of this type of personality, and the absence of evidence to indicate that the great bulk of humanity is incapable of attaining it, is most encouraging for those concerned with a constructive program of mental hygiene.

3. Desirable and constructive personality is built or produced (results from directed differentiation and integration) and does not simply grow. It is impossible to say what human personality[1] in the raw (without refinement) would be like. Even in the most primitive of savage societies there are the beginnings or elements of culture which are built into the personalities of the rising generation.

There is no psychological theory that will serve as an adequate theoretical basis for the contention that personality is the result of growth in the sense that the body is the result of growth. Space does not permit an examination of the foremost present-day theories of the development of the mind; it will suffice to mention five of the most widely known of these theories to make it clear that no one of these hypotheses gives

[1] Character, in the psychological sense, is included in this term.

any comfort to those who would hold that personality just grows. Whether one believes that personality is made up of Watson and Pavlov's conditioned responses, of Thorndike's S–R connections, of James's or Dewey's dynamic habits, of Lewin's psychical systems, of McDougall's sentiments, or of Freud's ego and super-ego and their relations to each other and to the id—whatever our contention as to the essential element of mind—the rôle of experience is mammoth. The possibilities of modification are never questioned by these theorists. Mind and character are built out of experience. It is extremely easy to misinterpret a writer on this point. For example, Dr. McDougall has been widely misinterpreted in regard to his position as to the rôle of experience in personality development, in spite of his continued emphasis on the points that even the strength of the original propensities may be greatly modified in the course of the individual's life, and that character is a structure composed of sentiments. A brief quotation may convince the doubtful:

> "The budding emotions and sentiments are molded and encouraged along the right lines by absorption from the atmosphere about him. But if there are ugly things in that atmosphere, if the parents are such poor creatures that they are jealous of one another in respect of their children's affection, if they are quarrelsome, or untruthful, or mean, or greedy, or egotistical, if their relations to one another are in any way lacking in harmony and mutual respect, then, no matter how carefully they may try to hide these things, the child will suffer some distortion of development; in the worse cases there will be sown in him the seeds of future unhappiness and, not seldom, the beginnings of neurotic troubles that at any later period of strain may break out into manifest symptoms; stuttering, phobias, obsessions, perversions of all kinds, and the whole array of hysterical defects and neurasthenic sufferings. In many a family, neurotic disorders breaking out in successive generations are attributed to hereditary constitutional defects, when in reality they are due to lack of propitious family atmosphere, a lack which propagates itself from generation to generation in the forms of defects of character."[1]

I am not arguing for the *tabula rasa* of John Locke. The evidence is conclusively against such a position. Certainly there is an original basis to human nature. Without doubt this original stock has a great influence upon what the personality will become in a given case. I *am* contending that this original biological and psychological stock is the foundation—

[1] *Character and the Conduct of Life*, by William McDougall, M.D. New York: G. P. Putnam's Sons, 1927. p. 73,

or perhaps one should say the material—and by experiences this material is molded or differentiated into a particular structure. Stated in another way, the point is that the human species has a nervous system and an organic structure that make personality as we know it possible. Through the years personality has been enriched by the accumulation and transmission of culture. An illustration may be of value. Assume for the moment that any one of my readers had been placed at birth in an African tribe and had been brought up there. I do not *know,* but it seems highly probable that his personality in that case would have been very different from what it is now. The point in respect to the essential difference between the growth of the body and the so-called growth of personality will be clear if it is remembered that his body, within rather narrow limits, would have been quite the same in either case.

Now much has been said about the relation between the *psyche* and the *soma.* That the body and the mind are closely related and interrelated is accepted without question. This fact has been known at least since Aristotle and perhaps long before. But much error concerning human nature has been disseminated under the general theme, the relation between the *psyche* and the *soma.* It is common knowledge that many mental illnesses (notably, general paresis) result from organic lesion, or toxic effects. It is true, also, that a bad digestive system contributes, probably, to a bad disposition, but certainly there have been individuals with bad digestions and good dispositions. That the body affects the health of the mind is beyond reasonable doubt. But given a certain minimum requisite of bodily function, the health of the body remains the basically determining factor in mental health in only a relatively few pathological cases. Certainly it is more difficult to develop a healthy mind if the organic basis is in some way pathologically affected, but is not the evidence overwhelming that the body may be brought to a most horrible state and still the mind may remain clear and the personality harmonious and attractive? I know of no experimental evidence on the point, but my guess is that the deterioration of behavior in the case of general paretics would vary greatly, depending upon the integrity of their personalities before the

illness. In summary, it may be said that an integrated personality may be produced within very broad limits of organic condition.

Since the point I am attempting to make is crucial to my thesis, I shall introduce one other illustration. Many people contend that mental deficiency is sufficient explanation of delinquent behavior. For example, a girl of sixteen is a sex delinquent. She has an I.Q. of 70. The conclusion is that her intelligence is not sufficient to permit the development of proper inhibitions and proper choices. This conclusion seems tenable until one recalls that there is another girl in the same neighborhood with an I.Q. of 70 who is in no sense a behavior problem. Two girls in my home community come to mind. Both girls had I.Q.'s of approximately 60, certainly not higher than 70. Both enjoyed the very best of physical health. *A* was reared in a home that gave no attention to her education and permitted her to be molded by bad influences. She was, at the last account I had, plying the trade of a low-grade prostitute. *C* was reared by parents who recognized her handicap and took great care with her personality and character. She is now a fairly simple, but very pleasant and useful spinster of the highest respectability.

It may appear to some that in arguing at such length to establish the possibilities of human nature, I am attacking a straw man—that almost every one accepts the proposition that human character and personality (in the psychological sense) are to a great extent produced by experience and do not simply grow. On the contrary, it seems to me that our age is threatened with the stultifying illness of fatalism in respect to human nature and its possibilities. There is a widespread tendency to spurn and ridicule the age-old faith that man can reconstruct himself according to a more desirable plan. It has been oft repeated that the World War discredited this faith. The thin veneer of a cultivation based upon the relatively false dictum that to know the path of wisdom is to follow it gave way under the pressure of primitive emotion and urge, and truly the world was mad. But to acknowledge that a surface or apparent reconstruction of human nature proved weak and unenduring under strain in no sense means that a deeper reconstruction might not have

been effected, stronger and more enduring. Because a poor potter makes vessels that fall to pieces at the first test does not mean that the same clay in the hands of a more expert potter might not have been made into symmetrical and enduring vessels. Of course the potter figure is inaccurate because of the infinite complexity and dynamic nature of the raw material of the human organism, but as the complexity and dynamic nature of the raw material increase the difficulties of the building process, so also do these things increase the possibilities of the resulting structure.

This phase of my argument may be summarized thus: Mental health is the manifestation of desirable personality; desirable personality (at least in a highly complex society) is built or molded and does not simply grow.

4. It is the function of sound education to build healthy personality. Thus education becomes the extremely intricate and promising art of directing the differentiation and the organization of personality from birth until a self-directing, self-repairing maturity is attained. To deny the significance of education thus conceived is to accept the fatalistic assumption that the structure of individual personality is laid down once and for all by heredity, an assumption that is often vaguely made, but for which there is not the least empirical or theoretical evidence.

In general, then, it is the purpose of sound education to realize the possibilities of human nature as set forth in the preceding section. Such a program of education is the core of a mental-hygiene program from the educationist's point of view. Anything less than this is comparable to taking great care to keep an expert ambulance force at the bottom of a cliff instead of putting a railing at the point of danger. At best there will be a need for the specialist adept at reassembling disjointed structures (his task is difficult and requires a great special skill), but his work should increase rather than decrease interest in preventive measures.

Recently a prominent physician who specializes in the treatment of mental disorders stated with some feeling in a public address that it is crucial that all mental-hygiene activities be kept in the hands of the medical profession. One finds it difficult to understand such a contention. Did this eminent physi-

cian mean to say that the medical profession in his state wishes to accept the responsibility of directing the personality and character development of the children of the state? He could not have meant this, for that would imply that every parent and teacher in the state would have to become a physician. If I understand the speaker aright, he was stating that to him mental hygiene principally involves the treatment and care of mental disorder, and if this was his meaning all would agree that the treatment of mental disorder is a work for those expertly trained in this art. But my whole argument in this paper is pointed against limiting a mental-hygiene program by such a narrow, negative, unpromising, and unwarranted conception. It may be, as we suggested earlier, that the term mental hygiene cannot cover both what the educationist is thinking of and what the person interested in the treatment of pathological manifestations is thinking of. My judgment is that the greatest hope for improved mental health lies in close, sympathetic coöperation between all persons and agencies that can contribute either in theory or practice to the development and maintenance of mental health in the general population.

Be that as it may, I am suggesting that the purpose of education is to produce personalities that are healthy. Such a program of education includes all the influences that bear upon the developing individual. Among these inflences four are crucial—namely, the parents and the home they create; the system of formal education; the Church and its auxiliaries; and, finally, the less readily classifiable social influences, especially the recreational facilities. Although all of these factors are important, the relation of only one of these forces to the problem of mental health can be outlined here—namely, the system of education.

Whether or not one believes that it should be so, one cannot deny the fact that more and more the chief responsibility for the hygienic development of personality is being laid at the door of the schools. Thus, as education becomes an indispensable and respected profession, those engaged in the direction of the processes of education cease to be mere clerks, teaching in routine and unhygienic fashion the three R's and some of their derivatives, and become the accepted experts

in the community in matters pertaining to hygienic education. That is, the teacher expertly trained and adequately supported will accept a major portion of the task (a mammoth task and some would argue an impossible one) of educating—*i.e.*, developing wholesome personalities in—each generation of a nation of people.

It seems that no one else in modern life will or can accept this responsibility.[1] The parent is busily occupied with the complexities of modern life, with social activities at one end of the scale and economic necessities at the other end. One conscientious parent remarked: "I have set aside one hour each day to be with my child and care for his education." Until kindergarten age the remainder of waking life would be spent with a completely untrained nurse, and after that the child's time would be partitioned between school, nurse, and chance influences. The minister and the church see children very little. The doctor sees them after things have gone unbearably wrong.

One must hasten to add what must be in your minds already —namely, that education is unprepared to accomplish its basic function effectively. Only recently has education been conceived in its true sense, and even now the conception remains largely theoretical—an ideal. One might add that it is almost impossible for one bound by the traditional, intellectualistic notion of education to free himself sufficiently to think of education as the processes involved in the development of personality and character. Yet it is encouraging to note that the conception of education we have attempted to outline is becoming widely and deeply accepted as the only sound goal or ideal for public education. Changes in practical procedures will slowly follow this basic change in theory.

[1] In making these remarks, I am not unmindful of the inestimable significance of the parent in the educative process. But I do not have much hope for the reëducation of mature parents. Let us do what we can in this direction and it may be some gradual change of attitude may be attained, for I think William James overstated the hopeless rigidity of the adult personality; yet he certainly had a point, as any one who has attempted to change himself or others after thirty surely knows. It is of some interest to note in passing that the majority of the people whom we train for public education marry and become parents. This fact places a great burden on teacher training and has tended to lower its standards; at the same time, as our teachers become more expertly trained, this shift from the profession of teaching to the profession of parenthood means better trained parents. This, I think, is a very promising prospect.

Let us briefly summarize the factors that favor the achievement of this type of education. First, there is the growing conviction that the goal of education is the wholesome personality of those educated. Second, those engaged in education have, in general, a very keen faculty of self-criticism. Professional meetings are often largely made up of sharp-edged indictments. Perhaps a little professional ethics is needed in the teaching profession, but I sincerely hope teachers will never achieve a type of "ethics" that stifles self-criticism. Third, there is a growing tendency toward an openness to new ideas, a tendency sometimes exploited by fad peddlers; but perhaps it is better to stumble than never to walk. Finally, there is a growing literature on positive mental hygiene—hygienic education and reëducation—based upon all that the sciences of psychology, sociology, biology and medicine, theology, and the rest that concern themselves with human beings and human nature, can contribute. Up to this time the literature has been fragmentary, confused, and sometimes erroneous, but gradually the materials for a science of hygienic education are being discovered and organized. These facts and principles, as they are discovered and organized, will constitute the indispensable source materials to be used in the training of persons expert in the supervision of personality development.

That is the bright side. In what respects is our educational system unprepared to inaugurate and carry out a program of hygienic education? Since I believe an answer to that question is of vital concern to the problem of mental health, I shall close my paper with a brief outline of these inadequacies, all of which, in my judgment, are capable of being overcome.

1. The teacher (who is the essence of any educational endeavor) must become adequate in personality and training for the work outlined. This involves at least three basic issues: first, a training designed to make one expert in the matters of personality and character development; second, a teaching personnel with higher ability; and third, a teaching group who are themselves better adjusted to life. One of the most far-reaching tragedies of our culture lies in the fact that in the main our children are educated by persons who are themselves very often unhappy and unable to live effective

lives. This situation can be improved by providing a more adequate standard of living for these people; by providing the requisites of a reasonable security; by cutting the work requirements at least to the limits of human endurance; and by giving teachers an opportunity to live a reasonably free, unhampered, and satisfying life. So long as these things are not provided, so long shall the public reap the certain reward of poor and even harmful education.

2. The school curriculum was organized to impart knowledge and not to *educate* the children. The curriculum must be reorganized in terms of the purposes of a functional education. Many attempts are being made to change the curriculum, but in the main they are confused and abortive. This failure results from at least three causes. First, tradition makes any real change difficult—*e.g.*, perspective remains narrow. Second, the curriculum is largely what the teacher and the school administrator make it. Finally, the concept of hygienic education is so new that knowledge of the best materials of education is lacking.

3. There is a lack of unity in the school system itself. Disjointed, patchwork-quilt efforts are fairly effective for a knowledge type of education, but completely inadequate, except by chance, for a wholesome development of the personality of the child over a period of years. The whole time-spending, credit-accumulating system is clearly conceived in terms of knowledge, as opposed to a more comprehensive type of education.

4. The school has the reputation (implicit and sometimes expressed) of being a thwarting, narrow, distasteful, necessary evil that for some reason must be tolerated. It is most difficult for an institution with this flavor to *educate* children. It is only fair to remark that the schools are rapidly overcoming their original reputation; children live happily at some of the better schools now.

5. The home and external sociological factors must be made conducive to hygienic education as soon as knowledge and practical obstacles permit. This is important, for much that the school attempts to do may be neutralized by home and street influences. More positively stated, there is a need for intelligent and continuous coöperation between home and

school. In many communities the Parent-Teacher organization is doing much to increase the coöperation between these two institutions.

6. Finally—and this is, I think, our greatest need—there is the need for a fuller knowledge of the factors and conditions that make for desirable personality on the one hand and for undesirable personality on the other. There is sore need for a fuller knowledge of the forerunners of serious deviation. Gradually, as we have said, such information is being accumulated and organized. A real science of hygienic education must await facts and principles that can be supplied only by psychological research and investigation, carried on by any one who has the energy and insight to do such work. This knowledge, as it is acquired, must be assimilated and integrated into a theory of education that can be used to guide and unify educational procedure. This is the hope of the educationist for widespread improvement in mental health.

# PSYCHIATRY AND PROTECTIVE WORK *

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DURING the period from April, 1934, to July, 1935, I had the opportunity of serving as psychiatric consultant, on a part-time basis, to the Brooklyn Society for the Prevention of Cruelty to Children.[1] In the opinion of that agency, the temporary experiment had certain unusual features, and a short report on it is, therefore, warranted.

It should be clearly understood that the experiment had no direct scientific purpose. There were no peepholes, no guinea pigs, no controls. Over a period of years, the society had encountered a great many cases in which mental disease or defect played a considerable part by its occurrence either in children or in their parents or guardians. Mental disorder in children placed temporarily under the control of the society did not constitute a great problem, because such cases could be handled through the clinical facilities of the courts or through other public agencies and hospitals. Apparent mental disturbance affecting adults in the homes of children was a much more difficult problem. Seldom would persons so affected readily consent to examination in well-known mental clinics; and when such consent could be obtained, questions of time and distance caused considerable difficulty. The majority of such people—and their relatives—feared even the suggestion of mental clinics or hospitals. The machinery provided for placing such cases under observation was difficult to set in motion and to keep in motion, seemed to apply only to the obviously violent or disturbed patient, and apparently moved in fear of its own shadow. It may be added that this agency does not employ psychiatrically trained social

* Presented at the New York State Conference of Social Work, New York City, October 21, 1937.

[1] The author would like to take this opportunity to offer belated thanks to the society for their ever-ready coöperation.

workers. It is my understanding that all of these factors combined to cause the society to take the precarious step of introducing a psychiatrist into the family of protective workers.

It was my function, during those hours devoted to the society, to sit in conference on problems that involved or suggested the presence of a mentally diseased parent or guardian, to view or examine such cases as could be brought to the society office, and on numerous occasions to go to the patient's home, accompanied by an agent of the society, to study conditions at first-hand. The last mentioned approach is not commonly employed. It need hardly be added that many factors had to be taken into consideration before a journey to the patient was thought expedient. The justification, in my opinion, always rested on a case-work basis; although we were able to add the fact that a direct view of the entire situation, including the patient in his or her natural setting, is of vastly more importance in psychiatric work than in other fields of medicine. In any event, under seeming justification, Mohammed went to the mountain—although Mohammed was often in danger of confusing himself with Don Quixote. It was also found advisable to give a series of lectures to the staff of the society, and something will be said about this presently.

A total of eighty cases were brought to my attention. Seventy-two were given a variable amount of service; some cases were seen several times, while others justified drastic action on the first visit. Emphasis was placed upon the attempt to remedy the situation rather than upon the application of therapy to the individual. About this, too, more will be said later. A wide variety of psychiatric conditions were represented, including most of the known categories. Schizophrenia outnumbered all other diseases, while neuroses were plentiful. No attempt was made to classify them by diagnoses. Diagnosis, of course, was useful as an indicator of the type of treatment that would benefit the individual. But the society was primarily concerned with the total situation—*i.e.*, the case in terms of the function of the society, and as the situation might affect the welfare of the child within it—and with the possibilities for its rapid amelioration, by intensive case-

work, by treatment or removal of the patient, by display of authority, removal of the child, proper placement, and so forth. It will be seen that on occasion there was a clash between the interests of the child and those of the adults involved.

Certain factors, some commonly known and others less well appreciated, in addition to the presence of a mental disorder, were seen to be of importance, when taken in conjunction with the mental disorder, in aiding or retarding the amelioration of the situation. These may be referred to briefly with some illustrations. Often the society's agent, merely as a lay person, had had no difficulty in recognizing the presence of a mental disease. If the patient has been violent, and if the violence has been directed toward the marital partner, the latter is probably very willing to petition for the commitment of the patient, especially when morally supported or prodded into action by the agent. It is, nevertheless, surprising how frequently action is delayed for months or years. Often quite startling changes take place where delay in handling a mental case has been prolonged.

> Mrs. C. is now pregnant and insane. Since the case was first opened by a social agency nine years ago, there have been many charges of delinquency against three of her sons. Nine years ago, the youngest son was four years of age; to-day he is thirteen and has spent some time in a correctional institution. In other words, children who are little affected at the onset of the problem present additional problems during the period in which several agencies are spending time and money assisting the family in various ways. In this case, the children now treat their mother as if she were another child.

Common causes of such delay are ignorance on the part of responsible persons, opposition on the part of relatives, fear of consequences, pure inertia, and difficulty in obtaining impressive facts with which to start the necessary machinery. To this heterogeneous list may be added bureaucracy and incompetency in public agencies.

> Mary B., aged thirty-eight, Hebrew, married, appeared to be so incompetent mentally that she was unable to take any responsibility, and, in fact, was herself recognized as a great care. Domestic help would not remain in the house with her. As a result, her mother had been taking care of the patient's home to the point where she was worn out and unable to continue.
>
> The patient was found sitting in a chair in the darkest corner of the

dining room, clad in a house dress, without shoes or stockings. She was essentially mute and inaccessible to questions. For the most part, she stared directly in front of her with a fixed, half-hearted smile. Occasionally, there were furtive gestures and peculiar mannerisms. The case was rather typically one of schizophrenia, the catatonic type, and was quite obviously a hospital case. The husband admitted that he had realized his wife was a mental case, but he feared that her family would strongly oppose him in any action to have her committed. A fair amount of persuasion failed to arouse sufficient initiative. He spoke of threats, actual and implied, on the part of her family to wreak vengeance upon him. He believed that his wife's brother would kill him if he took such a step. A sister of the patient, with not more than average intelligence, could not understand why the patient required treatment, and actively opposed any suggestions in this direction. The husband admitted that his wife had repeatedly attacked him, and just a few days before had attempted to choke him in one of her violent and disturbed periods. A daughter, aged nine, was bearing most of the burden of her mother's illness.

Of course, a strong appeal was made to this husband on the grounds of his real responsibilities toward his wife and children. In any event, a hospital ambulance would not hesitate to remove such a case.

In another case, a woman of middle age was reported by the neighbors for abusing her sixteen-year-old daughter. A great deal of quarreling at night had been heard, and it was suspected that the mother was of unsound mind. The society's agent found that the woman, a widow, was rather peculiar in her manner and actions, inclined to be suspicious, but quiet and not obviously abnormal. She refused to go to a mental clinic. The psychiatrist was able, by a display of sympathy and mysterious secrecy, to uncover a paranoid trend of dangerous character directed against the daughter. The patient believed that her daughter was plotting to kill her, and that she was merely defending herself. The nearest adult relative, a brother, could not be persuaded of his sister's abnormality, and indicated that he would oppose any legal action by the society. The choice lay between removal of the daughter, leaving the mother to shift for herself, and engaging in time-consuming proceedings with probable opposition in a case where the patient had merely to remain uncommunicative to stand a good chance of escaping commitment.

Numerous cases could be cited to illustrate the difficulty in obtaining facts to support legal action. Many of these patients are sufficiently alert to avoid all discussion of their delusions in the presence of social workers or agents, or they can create such a plausible case against the husband, or some other person, that considerable observation is necessary to separate fact from fancy.

In one such case, a married woman, forty-one years of age, the mother of four children, had been a patient at Kings Park State Hospital, suffering from manic-depressive psychosis. She had had two other

admissions to state hospitals, but on each occasion had seemed to make a satisfactory recovery. Her husband alleged that she was mentally unfit to care for her home or her children. This the patient denied, and she countered with a convincing story of her husband's infidelity, presenting a typical picture of the woman scorned; and certainly, in this respect, her emotional reaction was adequate. A certain degree of simplicity, however, suggested defective or at least border-line intelligence. She could point to definite causes for her previous attacks of mental disorder. The husband, on the other hand, was quite apparently neurotic, and told a scarcely convincing story of his relationship with another woman.

In the midst of the investigation, the husband rather suddenly showed a desire to remain at home, although he admitted that he had no affection for his wife, and took no pains to conceal this. It was difficult to show him that his presence under such circumstances could do nothing but aggravate his wife's feelings.

The oldest daughter, aged nineteen, obviously wished to defend her father, and was quite antagonistic on the ground that the society seemed to be favoring her mother. The mother's incompetence had certainly lost the daughter's respect. Much time was needed to get at the truth. Meanwhile, steps were taken to alleviate the tension in the home, and to institute treatment for the husband's neurosis. The wife failed to show any definite symptoms of a psychosis.

Another woman, a long-standing case of schizophrenia, but well behaved and not apparently delusional, had been able to present such a clear case of neglect, cruelty, and alcoholism on the part of her husband that he was much too vulnerable to institute court action, since she would probably have elicited a great deal of sympathy. Such cases require much spade work to reveal the essentials in a clearer light. This case also revealed a regrettable procrastination. The family court had seen the patient on more than one occasion when she sought redress in the matter of her husband's behavior, and when she was often distinctly abnormal in her behavior. Here the matter of court jurisdiction was a stumblingblock.

In many cases economic factors impede the prompt institution of treatment. A husband's pension may be in his wife's name, or a commitment may break up the home and stop income from the home-relief bureau.

The problem of mental defectives came up quite frequently. I refer here to parents who have a record of at least some period of fairly adequate adjustment. Such cases are likely to show abnormality of conduct episodically, when the load is increased by added responsibility or by illness.

Thus, a man, aged sixty-one, and his wife, fifty, both of defective intelligence, had fifteen children, of whom twelve were living. The oldest child was married; three of the others were maintaining themselves by working; six were still in school; one was in a reformatory;

and one a patient in a mental hospital. From the point of view of the community, these people had been considered competent to care for their children over a period of many years. A heart condition finally developed in the husband, and this, plus increasing economic stress, overtaxed his capacity. He was no longer able to adjust to his situation, and his wife, who had leaned on him for years, toppled with him. No disharmony arose between these two persons, and the removal of some of the children relieved the situation. The question, of course, arose, Was their care of these children ever adequate? Did not Society neglect the whole family?

Sometimes, as in the case of Mrs. A. L., little or no responsibility can be carried. She was able to get along well with her children, when in the home of and under the guidance of her mother, who was dominant and through whom the society was able to control the situation. This parentalization has been the means of keeping many persons out of institutions and at a useful level of adjustment in the community.

When the coöperation of relatives can be obtained, it is a most desirable and useful tool.

Mrs. B. E., a young mother, was found to be a deteriorated, apathetic, and incompetent schizophrenic. What little emotion she showed was directed almost exclusively toward her baby. She seemed at times to recognize that she had become worse since her discharge from a mental hospital, but moods in which she might consider returning voluntarily to the hospital were quickly terminated by the thought of having to leave the baby. Her behavior would not have impressed an ambulance doctor on short contact as particularly abnormal. There was considerable delay, until a daughter in her teens coöperated in a strategic move in which the younger children were taken out for a walk and then removed to the society, while this daughter returned and persuaded her mother to go back to the hospital.

So many rough spots are made smooth by the coöperation of relatives that time spent in an effort to obtain it is seldom regretted.

In other cases an excellent case-work result had been threatened with failure by the worker's inability to persuade the family of the necessity for hospital treatment. Here the voice of medical authority may be welcomed, if pains are taken to keep it distinctly free from any other authority.

The relationship of abnormal behavior to toxic states and other serious medical conditions deserves mention. Mental conditions due to toxins in the body will not, of course, be relieved until these substances are removed by medical means.

If the social worker considers this possibility, a good general practitioner may do much to remove a mental-hygiene problem.

It might appear from what I have said, and from the brief citations of case material, that there was in this work frequent recourse to the courts. As a matter of fact, the situation was exactly the opposite. Appeal to any court by any worker of the society was very rare in the series of mental cases to which I refer. In fact, it was seldom necessary to wield a big stick at all. However, numerous persons involved in these case problems expressed dissatisfaction with the help they had been able to obtain from appeal to courts. Some of these complaints were, of course, quite unjustified. When they were legitimate, the faults did not lie so much in the field of well-defined functions of the court as in implied possibilities for help. Until all the factors in a case of this kind have been studied, legal issues cannot become clearly defined. They may not arise at all. Most of the factors are, in the last analysis, emotional in character. It is true that courts have become more and more receptive to the extra-legal aspects of cases and to assistance from the investigator and the expert. The news does not appear to have reached some magistrates.

This, however, does touch upon a matter about which I should like to digress—if a psychiatrist, in his extenuating ignorance, may be permitted to attack the subject of protection and the rôle of protective agencies. Protection is usually thought of in terms of children or of certain helpless or defective adults. In a more primitive state, certainly, adulthood implied facility in self-protection. But more and more, in highly organized modern society, man has had to specialize in and to delimit his endeavors, delegating his own protection to government and its agencies. He has become quite unfitted to fall back upon his own resources for protection. If the delegated function is inadequately fulfilled, he is more helpless than he was in primitive society. Similarly, the increasing assumption of certain duties by schools, community centers, associations, and societies renders parents less and less competent to exercise a protective rôle with regard to children. Reliance is being placed upon the continuous and

competent function of public agencies and of the law. But in the past the small voice of the individual was magnified and made audible by the private agency. The personal factor and certain other functions of private character can only be handled privately. The shift of responsibility to public agencies has resulted in their rapid multiplication. There is some overlapping of work and responsibility, and a danger that a mouthpiece of private need may be stifled. On the part of public agencies there is too much recourse to legal proceedings. The majority of inimical influences that come to bear upon children, and indeed upon adults, are not criminal in purpose or in degree. They cannot be dismissed by a verdict of guilty or not guilty. They will, however, respond to attempts at understanding on a case-work basis. The case-worker is an excellent liaison officer, even when these problems of interpersonal relationships do demand authoritative action in the common weal.

Psychiatry is essentially a study of interpersonal relations, bringing to the problems in this field a special technique and all of the resources of medicine. In my last remarks I have indicated a medical attitude—namely, that doctors should study, understand, and by all means modify situations for the better, but never condemn. It is my belief that the private protective agency will also find its primary function approximating just such an approach to the social body. In the matter of the maternal instinct, for example, every agent knows what stormy seas may be aroused by the mere threat of a display of legal authority, when preparatory work has not been adequate.

It is scarcely necessary for me to say that the psychiatric approach is imperative in many of these problems. What does an agency such as the S. P. C. C. want from psychiatry? Does it want a specialized opinion for its authoritative weight—in other words, a special form of "big stick"? There are alienists in public clinics who can meet this need in many cases. Does it want help with its behavior problems in children? There are to-day many clinics available for this purpose. Does it want help in understanding adults and their problems in certain settings, with or without thought of using its authority? Again, certain cases may be handled through clinics.

But just as in private practice some cases by their nature must be seen at home, so many of these cases demand a private psychiatric approach. The psychiatrically trained social worker has a place here, too, in expediting action, if not in initiating it.

The attitude of the psychiatrist is all-important. While his interpretation of the facts must be correct and must reflect an adequate experience, the scientific attitude must be controlled. He must recognize that, as Dr. Harry Stack Sullivan has recently said, "very few people show much 'sense' in interpersonal relations, and almost every one deals with other people with a wonderful blend of magic, illusions, and incoherent irrelevancy." An understanding of problems of behavior requires a grasp of the serial order of the stages of development of the human mind and its physical concomitants. A series of talks were given to the agents of the society with this in mind. Development, when up against indigestible and unalterable circumstances, comes to a full stop. Immediately the former evidences of identification with the other fellow or the group tend to be less apparent. When out of step, the unique individuality of the person comes to the fore. Incidentally, the psychiatrist and the social worker show this just as clearly as the deluded individual. It is important to maintain a human identification with the patient by some method. It is also vital that the psychiatrist take a stand somewhere, rightly or wrongly, between a *laissez-faire* aloofness and an all-embracing paternalism. Doctors usually combine these attitudes to an interesting degree.

Certain problems arise in the mind of the psychiatrist concerning his duty to the patient and to the children involved. This is further complicated by the aims and duties of the society. One must guard against undue invasion of the privacy of the home under what may amount to false pretenses. I think I went to the homes of patients too often. Agents or workers are naturally pleased to have the responsibility shared by an accompanying physician. On the other hand, the possibility of materially altering a bad situation of long standing must take precedence over many poorly grounded scruples. And, more often than not, I think the patient found a friend, and did not think less of the society.

# MARRIAGE RATES AMONG PATIENTS WITH MENTAL DISEASE

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IT is known that rates of first admissions to hospitals for patients with mental disease vary in accordance with the marital condition of the general population. Such rates are highest among the divorced population and lowest among the married. However, the former constitute but a relatively small percentage of the general population, and hence exercise small weight in determining rates of mental disease for the population as a whole. If one disregards the divorced population, it then appears that the highest rate of mental disease occurs among the single population. Rates of first admission among the single and the married, when corrected for age differences, are in the ratio of 2.4 to 1.

This is a fact of deep sociological significance. Nevertheless, it appears of greater importance to reverse the question, and to ask, not what are the rates of mental disease in the several marital groups, but what are the marriage rates among patients with mental disease. The latter point of view is closely associated with the inheritance of mental diseases. If inheritance is a significant factor in the causation of such diseases, its effects will manifest themselves as consequences of differential marriage and birth rates. What, then, are the facts with respect to rates of marriage among patients with mental disease?

It is very simple to demonstrate algebraically that, if the married population has a lower rate of first admissions than the general population, then patients with mental disease must have a lower marriage rate than the general population.[1]

[1] Let the first admissions be represented by A, and the married first admissions by a. Let the general population and the total married be represented by P and p respectively. We wish to show that a/A is less than p/P. Now it is known from previous investigations that a/p is less than A/P. By cross multiplication and division it follows that a/A must be less than p/P—that is, the marriage rate of first admissions is less than that of the general population.

But of greater value is a detailed discussion of marriage rates among first admissions, showing their variations with respect to age, sex, and psychosis. We proceed, therefore, to a description of marriage rates among the first admissions, aged 15 years and over, to all hospitals for mental diseases in New York State during the fiscal years 1929 to 1931, inclusive.

Table 1 shows that there were 15,762 male first admissions, of whom 6,785, or 43.0 per cent, were single, and 8,809, or 55.9

TABLE 1.—FIRST ADMISSIONS TO ALL INSTITUTIONS FOR MENTAL DISEASE IN NEW YORK STATE, AGED FIFTEEN YEARS AND OVER, DURING THE FISCAL YEARS 1929–1931, CLASSIFIED ACCORDING TO MARITAL STATE AND AGE.

| | MALE | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | *Total* | | *Single* | | *Married* | | *Unknown* | |
| *Age in years* | No. | Per cent | No. | Per cent | No. | Per cent | No. | Per cent |
| 15–19..... | 745 | 100 | 739 | 99.2 | 6 | 0.8 | .. | ... |
| 20–24..... | 1,275 | 100 | 1,191 | 93.4 | 83 | 6.5 | 1 | 0.1 |
| 25–29..... | 1,455 | 100 | 1,110 | 76.3 | 330 | 22.7 | 15 | 1.0 |
| 30–34..... | 1,521 | 100 | 816 | 53.6 | 693 | 45.6 | 12 | 0.8 |
| 35–39..... | 1,792 | 100 | 728 | 40.6 | 1,045 | 58.3 | 19 | 1.1 |
| 40–44..... | 1,634 | 100 | 538 | 32.9 | 1,086 | 66.5 | 10 | 0.6 |
| 45–49..... | 1,452 | 100 | 434 | 29.9 | 1,002 | 69.0 | 16 | 1.1 |
| 50–54..... | 1,285 | 100 | 327 | 25.4 | 933 | 72.6 | 25 | 1.9 |
| 55–59..... | 1,036 | 100 | 262 | 25.3 | 762 | 73.6 | 12 | 1.2 |
| 60–64..... | 962 | 100 | 204 | 21.2 | 741 | 77.0 | 17 | 1.8 |
| 65–69..... | 851 | 100 | 179 | 21.0 | 661 | 77.7 | 11 | 1.3 |
| 70–74..... | 790 | 100 | 131 | 16.6 | 650 | 82.3 | 9 | 1.1 |
| 75 and over... | 939 | 100 | 120 | 12.8 | 806 | 85.8 | 13 | 1.4 |
| Unknown..... | 25 | 100 | 6 | 24.0 | 11 | 44.0 | 8 | 32.0 |
| | 15,762 | 100 | 6,785 | 43.0 | 8,809 | 55.9 | 168 | 1.1 |
| | FEMALE | | | | | | | |
| 15–19..... | 539 | 100 | 486 | 90.2 | 52 | 9.6 | 1 | 0.2 |
| 20–24..... | 981 | 100 | 629 | 64.1 | 350 | 35.7 | 2 | 0.2 |
| 25–29..... | 1,152 | 100 | 468 | 40.6 | 683 | 59.3 | 1 | 0.1 |
| 30–34..... | 1,293 | 100 | 373 | 28.8 | 916 | 70.8 | 4 | 0.3 |
| 35–39..... | 1,351 | 100 | 293 | 21.7 | 1,052 | 77.9 | 6 | 0.4 |
| 40–44..... | 1,292 | 100 | 305 | 23.6 | 979 | 75.8 | 8 | 0.6 |
| 45–49..... | 1,080 | 100 | 211 | 19.5 | 864 | 80.0 | 5 | 0.5 |
| 50–54..... | 990 | 100 | 214 | 21.6 | 771 | 77.9 | 5 | 0.5 |
| 55–59..... | 805 | 100 | 165 | 20.5 | 633 | 78.6 | 7 | 0.9 |
| 60–64..... | 715 | 100 | 154 | 21.5 | 555 | 77.6 | 6 | 0.8 |
| 65–69..... | 681 | 100 | 112 | 16.4 | 566 | 83.1 | 3 | 0.4 |
| 70–74..... | 661 | 100 | 116 | 17.5 | 537 | 81.2 | 8 | 1.2 |
| 75 and over... | 1,039 | 100 | 159 | 15.3 | 873 | 84.0 | 7 | 0.7 |
| Unknown..... | 18 | 100 | 3 | 16.7 | 7 | 38.9 | 8 | 44.4 |
| Total..... | 12,597 | 100 | 3,688 | 29.3 | 8,838 | 70.2 | 71 | 0.6 |

per cent, were either married, widowed, divorced, or separated. In 168 cases the marital status was unknown. On April 1, 1930, the male population of New York State, aged 15 years and over, had a marriage rate of 63.2 per cent. On the basis of "crude" rates, therefore, the general male population had a marriage rate in excess of that of the male patients by 11.3 per cent. Actually, however, the discrepancy is much greater, because the "crude" marriage rates are influenced by the respective age distributions of the two groups. The patients are older than the general population, and since the marriage rate is correlated with age, the former will tend to have a higher marriage rate.

The variation of the marriage rate with age is shown in Table 2. Marriage rates in the male population increased

TABLE 2.—PER CENT MARRIED AMONG THE POPULATION OF NEW YORK STATE, APRIL 1, 1930, AND AMONG FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1929–1931, ACCORDING TO SEX AND AGE.

| | *Males* | | | *Females* | | |
|---|---|---|---|---|---|---|
| | General population (a) | First admissions (b) | Ratio of (a) to (b) (c) | General population (a) | First admissions (b) | Ratio of (a) to (b) (c) |
| *Age in years* | | | | | | |
| 15–19 | 0.6 | 0.8 | 0.8 | 6.2 | 9.6 | 0.6 |
| 20–24 | 18.1 | 6.5 | 2.8 | 41.2 | 35.7 | 1.2 |
| 25–29 | 53.1 | 22.7 | 2.3 | 70.3 | 59.3 | 1.2 |
| 30–34 | 73.5 | 45.6 | 1.6 | 82.4 | 70.8 | 1.2 |
| 35–39 | 81.8 | 58.3 | 1.4 | 86.0 | 77.9 | 1.1 |
| 40–44 | 85.1 | 66.5 | 1.3 | 87.4 | 75.8 | 1.2 |
| 45–49 | 86.7 | 69.0 | 1.3 | 87.9 | 80.0 | 1.1 |
| 50–54 | 87.6 | 72.6 | 1.2 | 87.6 | 77.9 | 1.1 |
| 55–59 | 88.3 | 73.6 | 1.2 | 88.1 | 78.6 | 1.1 |
| 60–64 | 89.0 | 77.0 | 1.2 | 88.2 | 77.6 | 1.1 |
| 65–69 | 89.7 | 77.7 | 1.2 | 88.7 | 83.1 | 1.1 |
| 70–74 | 90.2 | 82.3 | 1.1 | 88.5 | 81.2 | 1.1 |
| 75 and over | 91.7 | 85.8 | 1.1 | 89.4 | 84.0 | 1.1 |
| Total | 63.2 | 55.9 | 1.1 | 69.7 | 70.2 | 1.0 |

rapidly from 0.6 per cent at 15–19 years to 18.1 per cent at 20–24 years, and to 53.1 per cent at 25–29 years. The marriage rate continued to grow to a maximum of 91.7 per cent among those aged 75 years and over, but after the fortieth year the increase was at a relatively slow rate. A similar picture is shown by male first admissions, their marriage rate

rising rapidly up to age 40, and slowly thereafter. Excluding the age interval 15–19 years, the marriage rate of the general male population was in excess of that of the patients. The excess was especially noticeable at the younger ages. At 20–24 years the rate of the general population was in excess in the ratio of 2.8 to 1. With advancing age the disparity between the two sets of rates was gradually reduced, until at 70 years and over the marriage rate of the general population was in excess in the ratio of only 1.1 to 1. Assuming, now, that the male first admissions had been distributed in the same age proportions as the general male population, aged 15 years and over, and applying the specific marriage rates at each age, we obtain a standardized marriage rate for the male first admissions of 46.0 per cent. This may be compared with the corresponding rate of 63.2 per cent for the general population. As a result of the age correction, the marriage rate of the latter is, therefore, in excess by $17.2 \pm 0.27$ per cent, instead of by only $7.3 \pm 0.27$ per cent.

There were 12,597 female first admissions, of whom 3,688, or 29.3 per cent, were single, and 8,838, or 70.2 per cent, were married, widowed, divorced, or separated. The marital status was unknown in 71 cases. The corresponding marriage rate for the general female population of New York State, aged 15 years and over, on April 1, 1930, was 69.7 per cent. Apparently, therefore, the patients had a higher marriage rate. But this was due entirely to selection with respect to age, the patients being older than the general population. Actually, the marriage rate of the general female population was in excess in every age interval, except the youngest. (See Table 2.) In the latter interval, the contrary result was probably due to chance fluctuations. Among the general female population, the marriage rate rose rapidly from 41.2 per cent at 20–24 years to 86.0 per cent at 35–39 years. Thereafter there was a slow, but steady rise to a maximum of 89.4 per cent at 75 years and over. Among the female first admissions, the marriage rate rose from 35.7 per cent at 20–24 years to 77.9 per cent at 35–39 years. The rate continued to rise slowly to a maximum of 84.0 per cent at 75 years and over. We noted, in the case of the males, that the general marriage rate was greatly in excess at the younger ages, but that there was a

gradual tapering-off in the relative differences with advancing age. Among the females, however, there was but slight variation with age. From 20 to 44 years the marriage rate of the general female population was in excess in ratios of 1.2 to 1. At the older ages the ratios were of the order of 1.1 to 1. We may also note that among the general population, females had a higher marriage rate than males up to the fiftieth year, whereas the rate of female patients was in excess of that of the male patients up to the seventieth year. Furthermore, prior to the fortieth year the disparity in the rates of the two sexes was much more marked among the patients.

Using the general male population of New York State, aged 15 years and over, as the standard population, we may recompute the marriage rate of the female patients. We then obtain a rate of 62.6 per cent. Standardizing the marriage rate of the general female population in a similar manner, we obtain a rate of 70.3 per cent. In other words, when age differences were accounted for, the marriage rate of the female population was in excess of that of the female first admissions by $7.7 \pm 0.29$ per cent.

From the preceding statistics it is evident that, though male and female first admissions both have lower marriage rates than the corresponding general populations, the disparity is more marked in the case of the males. Furthermore, the general female population had a standardized marriage rate of 70.3 per cent, compared with a rate of 63.2 per cent among the general male population, whereas the standardized rate of the female patients was in much greater relative excess over that of the male patients. Mental disease acts as a barrier to marriage, but is evidently less effective in the case of females. This is a consequence of courting principles. In our contemporary Western civilization it is the male who ordinarily makes the advances, but such initiative is lacking in many male patients with mental disease. Females, on the other hand, not finding it necessary to be aggressive in sexual contacts, can, nevertheless, be parties to courtship, especially when the disease is only in an incipient state, unrecognized as yet by the untrained observer. This explains why the marriage rates of the female patients were in noteworthy excess of those of the males in the second and third decades of life.

Though, as a group, patients with mental diseases have

lower marriage rates than the general population, we shall now show that this varies with type of mental disorder. We shall consider the five groups of mental disorders most important numerically. Tables 3 and 4 summarize the data for each of these groups among male and female first admissions, respectively.

TABLE 3.—PER CENT MARRIED AMONG THE MALE POPULATION OF NEW YORK STATE, APRIL 1, 1930, AND AMONG FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1929–31, CLASSIFIED ACCORDING TO AGE.

| *Age in years* | *New York State* | *Total first admissions* | *Psychoses with cerebral arteriosclerosis* | *General paresis* | *Alcoholic psychoses* | *Manic-depressive psychoses* | *Dementia praecox* |
|---|---|---|---|---|---|---|---|
| 15–19..... | 0.6 | 0.8 | .... | .... | .... | .... | 0.2 |
| 20–24..... | 18.1 | 6.5 | .... | 13.6 | 18.2 | 9.7 | 4.3 |
| 25–29..... | 53.1 | 22.7 | 100.0 | 45.8 | 34.8 | 33.1 | 15.8 |
| 30–34..... | 73.5 | 45.6 | .... | 71.0 | 54.4 | 50.7 | 31.7 |
| 35–39..... | 81.8 | 58.3 | 50.0 | 70.9 | 55.7 | 70.1 | 45.1 |
| 40–44..... | 85.1 | 66.5 | 80.0 | 75.8 | 67.6 | 75.7 | 54.2 |
| 45–49..... | 86.7 | 69.0 | 60.3 | 80.9 | 60.9 | 75.8 | 54.4 |
| 50–54..... | 87.6 | 72.6 | 71.0 | 77.7 | 70.8 | 74.6 | 66.0 |
| 55–59..... | 88.3 | 73.6 | 75.4 | 76.0 | 70.3 | 82.3 | 48.4 |
| 60–64..... | 89.0 | 77.0 | 79.5 | 75.0 | 72.2 | 90.4 | 65.6 |
| 65–69..... | 89.7 | 77.7 | 81.0 | 72.5 | 79.1 | 85.0 | 35.3 |
| 70–74..... | 90.2 | 82.3 | 84.0 | 82.4 | 63.6 | 100.0 | 100.0 |
| 75 and over. | 91.7 | 85.8 | 85.9 | 62.5 | 75.0 | 80.0 | 75.0 |
| Unknown... | 38.9 | 44.0 | 40.0 | .... | .... | 100.0 | 16.7 |
| Total..... | 63.2 | 55.9 | 80.1 | 73.5 | 62.2 | 54.5 | 27.8 |

*Psychoses with Cerebral Arteriosclerosis.*—There were 2,214 male first admissions with psychoses with cerebral arteriosclerosis, of whom 417, or 18.8 per cent, were single, and 1,773, or 80.1 per cent, were or had been married. The marital status was unknown in 24 cases. The marriage rate of the general male population aged 15 years and over was 63.2 per cent. The comparison is erroneous, however, since the patients were almost all over 45 years of age, whereas the general population included a considerable percentage of younger people. Using the general male population of New York State, aged 45 years and over, on April 1, 1930, as the base, we obtain a marriage rate of 88.2 per cent for the male population. Using the same population as the standard, we obtain a rate of 72.5 per cent for the male first admissions, which is significantly less than for the general population.

There were 1,705 female first admissions with such psy-

choses, of whom 285, or 16.7 per cent, were single, and 1,412, or 82.8 per cent, married. Eight patients were unclassified with respect to marital status. The "crude" marriage rate is, therefore, considerably in excess of the rate of 69.7 per cent for the general female population of New York State. When we correct for age composition, however, we find that the female patients really have a lower marriage rate than the general female population.

TABLE 4.—PER CENT MARRIED AMONG THE FEMALE POPULATION OF NEW YORK STATE, APRIL 1, 1930, AND AMONG FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1929–31, CLASSIFIED ACCORDING TO AGE.

| *Age in years* | *New York State* | *Total first admissions* | *Psychoses with cerebral arteriosclerosis* | *General paresis* | *Alcoholic psychoses* | *Manic-depressive psychoses* | *Dementia praecox* |
|---|---|---|---|---|---|---|---|
| 15–19..... | 6.2 | 9.6 | .... | .... | .... | 9.7 | 6.8 |
| 20–24..... | 41.2 | 35.7 | .... | 42.9 | 87.5 | 46.1 | 25.2 |
| 25–29..... | 70.3 | 59.3 | .... | 87.2 | 76.9 | 68.8 | 47.7 |
| 30–34..... | 82.4 | 70.8 | .... | 84.6 | 96.3 | 79.6 | 65.8 |
| 35–39..... | 86.0 | 77.9 | 66.7 | 92.5 | 88.6 | 84.7 | 71.8 |
| 40–44..... | 87.4 | 75.8 | 67.6 | 92.7 | 93.5 | 81.3 | 70.0 |
| 45–49..... | 87.9 | 80.0 | 83.3 | 94.3 | 93.7 | 84.9 | 75.4 |
| 50–54..... | 87.6 | 77.9 | 82.2 | 98.3 | 93.8 | 75.2 | 76.0 |
| 55–59..... | 88.1 | 78.6 | 82.0 | 90.7 | 83.3 | 76.6 | 73.8 |
| 60–64..... | 88.2 | 77.6 | 79.3 | 95.7 | 80.0 | 83.3 | 70.9 |
| 65–69..... | 88.7 | 83.1 | 85.4 | 100.0 | .... | 87.0 | 68.0 |
| 70–74..... | 88.5 | 81.2 | 85.3 | 100.0 | 100.0 | 81.8 | 91.7 |
| 75 and over. | 89.4 | 84.0 | 84.5 | 100.0 | .... | .... | 33.3 |
| Unknown... | 46.6 | 38.9 | .... | .... | .... | .... | 57.1 |
| Total..... | 69.7 | 70.2 | 82.8 | 90.0 | 90.6 | 69.1 | 58.6 |

Using the male population, aged 45 years and over, as the standard population, we obtain standardized marriage rates as follows: general female population, 88.1 per cent; female first admissions, 82.7 per cent. The difference is statistically significant.

It is clear, therefore, that patients with psychoses with cerebral arteriosclerosis have lower marriage rates than the general population. It is not apparent, on the surface, why this should be so, since such psychoses manifest themselves long after the age when most people have already married. Is there a correlation between early temperamentally abnormal mental traits and a predisposition to arteriosclerosis? Such a relation is not entirely fanciful, since it is now known that there is a correlation between longevity and early arterial

tension. It is possible that men and women predisposed to hypertension may possess peculiarities which encourage a celibate existence.

It is interesting to note that though the standardized marriage rates for males and females, 45 years of age and over, are equal, male first admissions with psychoses with cerebral arteriosclerosis have a significantly lower rate than female patients.

*General Paresis.*—Of the 2,328 male first admissions with general paresis, 585, or 25.1 per cent, were single, and 1,710, or 73.5 per cent, were or had been married. The marital status was not determined in 33 cases. The marriage rate is in excess of that of the general male population. The comparison is vitiated, however, by the fact of age selection, the patients being older than the general population. Comparing corresponding specific age marriage rates, we find those of the general male population in excess in ratios varying from 1.3 to 1 to 1.1 to 1. For purposes of comparison, the summary rates should, therefore, be standardized. The marriage rate for the general male population, aged 15 years and over, was 63.2 per cent. Using the same population as the standard, we obtain a rate of 55.8 per cent for the male patients. When age differences are eliminated, it thus appears that male general paretics have a significantly lower marriage rate than the general male population.

Of the 590 female first admissions with general paresis, 53, or 9.0 per cent, were single, 531, or 90.0 per cent, were married, and the marital status was unknown in 6 cases. The "crude" marriage rate is in excess of that for the general female population. The specific age rates are also higher for the female patients. Consequently, when we standardize the rates, by using the same standard population as for the males, we obtain rates of $70.3 \pm 0.01$ and $75.8 \pm 1.19$ per cent for the patients and the general population, respectively. The difference is statistically significant.

We thus observe that, although male patients with general paresis have a lower marriage rate than the general male population, female paretics have a higher rate than the general female population. The latter results, undoubtedly, from selective factors. The vast majority of women suffering with

syphilis have been infected by their spouses. Thus the presence of general paresis in a woman is almost equivalent to saying that she is married.

*Alcoholic Psychoses.*—There were 1,436 male first admissions with alcoholic psychoses, of whom 525, or 36.6 per cent, were single, and 893, or 62.2 per cent, married. Eighteen patients were unclassified with respect to marital status. The marriage rate is almost equivalent to that of the general male population. Because of age differences, however, it is necessary to standardize the rates. Using as standard the male population of New York State, aged 25 years and over on April 1, 1930, we obtain marriage rates of 79.3 and 59.4 per cent, for the male population and the male alcoholics, respectively.

In the case of the 276 female first admissions with alcoholic psychoses, 22, or 8.0 per cent, were single, and 250, or 90.6 per cent, were married. The marital status was unknown in 4 cases. The "crude" marriage rate is greatly in excess of that of the general female population. When age differences are allowed for through standardizing (as in the case of the males) the marriage rates become $88.5 \pm 1.31$ and $84.1 \pm 0.01$ per cent for the patients and the general population, respectively. The marriage rate of the female patients is in excess by only 4.4 per cent, but the difference is statistically significant.

Thus male alcoholics have a lower marriage rate than the general male population, but female alcoholics have a higher marriage rate than the general female population. The difference in trend may be ascribed to social factors. Alcoholism is an undoubted deterrent to marriage. Relatively few unmarried female alcoholics are able to find husbands. Alcoholic abuse by females is, therefore, likely to begin subsequent to their marriages. Social selection, therefore, accounts for the fact that the standardized marriage rate of female first admissions with alcoholic psychoses is almost 50 per cent in excess of that of the male patients.

*Manic-Depressive Psychoses.*—There were 1,456 male first admissions with manic-depressive psychoses. Of these, 653, or 44.8 per cent, were single, and 794, or 54.5 per cent, were married. The marital status of nine patients was unknown.

Marriage rates of the general population were in excess of those of the patients at corresponding ages, except for unimportant fluctuations at 60 years and over, due to small totals among the patients. The excess of the rates of the general population was especially noticeable in the age groups under 35 years. When the marriage rates were standardized (the male population, aged 15 years and over being used as standard), the discrepancy in the marriage rates was increased. The male population and the male patients had standardized marriage rates of 63.2 and 52.8 per cent, respectively.

Of the 2,218 female first admissions with manic-depressive psychoses, 683, or 30.8 per cent, were single; 1,533, or 69.1 per cent, were married; and the marital status was unascertained in 2 cases. The general female population had a "crude" marriage rate of 69.7 per cent, practically equivalent to that of the patients. Comparison of the specific marriage rates shows that the general population had rates slightly in excess of those of the patients at almost all equivalent ages. Consequently, when the rates are standardized, we obtain the following: general female population, $70.3 \pm 0.01$ per cent; female first admissions, $67.8 \pm 0.67$ per cent. The difference is on the border of statistical reliability.

It thus appears that the mental traits associated with manic-depressive psychoses result in a distinct lowering of the marriage rate of males, but have much less significance in the case of females.

*Dementia Praecox.*—Marriage rates are lowered most significantly among patients with dementia praecox. There were 4,144 such first admissions among males, of whom 2,973, or 71.7 per cent, were single, and 1,150, or 27.8 per cent, married. The marital status was unknown in 21 cases. Marriage rates of the general male population were greatly in excess of those of the patients at comparable ages, the differences being relatively largest in the twenties. Standardizing the marriage rate of the patients, the general male population, aged 15 years and over being used as base, we obtain a rate of 35.0 per cent, compared with 63.2 per cent for the general male population.

There were 3,525 female first admissions with dementia praecox, of whom 1,450, or 41.1 per cent, were single, and

2,066, or 58.6 per cent, married. The marital status was unknown in 9 cases. The corresponding crude marriage rate for the general population was 69.7 per cent. As in the case of the males, the marriage rates of the female population were markedly in excess of those of the patients at corresponding ages, especially in the twenties. Standardizing the marriage rates, we obtain the following: general female population, 70.3 per cent; female first admissions, 56.0 per cent.

It is thus evident that dementia praecox, a disease which strikes at the time of life when most people are preparing to marry, cuts down the marriage rate in significant proportions. But it is much more effective in preventing males from marrying, for the marriage rate of male patients is but 55.4 per cent of that of the general male population (giving due consideration to age differences), whereas that of female patients is 79.7 per cent of that of the general female population.

SUMMARY

1. Considering all first admissions as a group, we find that such patients have lower marriage rates than the general population. The difference is more marked in the case of male first admissions than in that of female first admissions.

2. Cerebral arteriosclerosis, which occurs late in life, and consequently long after the usual age at marriage, nevertheless is associated with lower marriage rates among first admissions with such psychoses.

3. Among patients with general paresis and alcoholic psychoses, male first admissions have lower marriage rates than the general male population, but female first admissions have higher rates than the general female population.

4. Male and female first admissions with manic-depressive psychoses both have lower marriage rates than the general population. In the case of the females, the difference, though probably statistically significant, is not very large.

5. Of all mental diseases, dementia praecox is the most effective in preventing marriage. This is especially true of male first admissions with dementia praecox, who marry at barely half the rate of the general male population.

# BOOK REVIEWS

THE AUTOBIOGRAPHY OF A PURPOSE. By William Alanson White, M.D. New York: Doubleday, Doran, and Company, 1938. 273 p.

This unique autobiography of Dr. William A. White is not so much a revelation of his personality and intimate life as it is an account of his professional career. He was led to adopt the title, *The Autobiography of a Purpose,* by noting in reviewing his life history that he had evidently been actuated by a definite purpose "nearly from the beginning, a purpose which was sponsored and directed, considerably at least if not altogether, by circumstances." The ultimate object of this purpose was "the finding out something about man's psyche, so that he might proceed along the lines of evolution and development without being everlastingly tied to the materialistic concepts of the nineteenth century." As Dr. White's publications, which are listed in a bibliography contained in this book, number more than two hundred and eighty titles, and as he made innumerable public addresses, besides teaching psychiatry and mental hygiene in two medical colleges, evidence of his faithfulness to his purpose is overwhelming. That he could do so much of this character, and so brilliantly, besides administering and developing one of the largest and finest psychiatric hospitals in the world, and taking a leading part in the principal local, national, and international psychiatric and mental-hygiene organizations, shows what an extraordinary person he was. He makes no mistake in assuming that "his personal experiences set down in a way that might prove interesting, helpful, illuminating, and suggestive to readers of many varieties would be a legitimate undertaking." As Dr. Ray Lyman Wilbur says in the Introduction, "out of it all has come a kindly, frank, and sane story of his life that will stimulate every reader."

Dr. White was, he says, "inclined to look for general principles" rather than "to be interested exclusively in details." His chapters on hospital administration and development, and on many of the problems met with in hospital and in community psychiatric practice, and in medico-legal work, reveal, therefore, the administrative, tactical, and ethical principles he followed, rather than details, though these are by no means entirely lacking. The titles of some of the chapters are: *Building a Great Hospital, Hospital Personnel, Factors of Importance in the Administration of a Hospital for Mental Disease, Correspondence, Consultations, Extra-Mural Activities, Medico-Legal Experience, Selling Psychiatry-Teaching, Paresis, Patients I Have*

*Known.* These chapters might with advantage be "required reading" for physicians entering the field of psychiatry, and they contain much of interest and value to all psychiatrists.

Dr. White has, in his numerous publications, fully set forth his views on various phases of psychiatry and mental-hygiene theory and practice that are more briefly discussed in this volume. It seems unnecessary, therefore, to discuss them in this review.

The simple facts of his life and career have, however, not before been so fully told, and it will add much to the interest and influence of his writings for his readers to become aware of the manner of man he was. To feel the quality and force of his personality, however, it is necessary to read his own words and to discern what can be learned of his personality "between the lines" as they appear in this book.

He was born in Brooklyn, New York, of New England parentage and his boyhood summers were spent with relatives in Massachusetts. From early childhood he was so eager for knowledge that a visitor dubbed him "Question Mark." He was also extremely industrious. In regard to this he says, "I can never remember when I was not busily engaged in something." He was conscientious to a degree. This he attributed to his New England origin and associations, and he was doggedly persistent in carrying to a finish anything he undertook, even in the reading of a book after it had ceased to interest him. He considered himself to be naturally "a shy man," and the facility in writing and speaking that he later displayed was "most laboriously acquired." He considered it fortunate that early in his professional career he took advantage of opportunities to attend regularly the meetings of the local medical society, and when first called upon to read a paper, to respond by doing so. He felt that if he had failed to grasp these early opportunities, he might never have been able to accomplish anything in either writing or speaking.

He met with great difficulties in obtaining a liberal education, and was obliged to earn the money for much of the expense involved. Educational standards and educational institutions were also not so well established as they are now. Dr. White entered high school at thirteen, and at fifteen he secured a scholarship at Cornell University. He had great difficulty with the entrance examinations, and was inadequately prepared for admission to the prescribed course for a degree. Undaunted, however, he remained at the university as a special student, selecting his subjects and completing four years of study. His interests inclined him to the courses that were calculated to lead to medicine as this was already his objective. He thought that the close proximity of his home to the Long Island

College Hospital and Medical College, and his association with the children of the professor of surgery, with whom he had free access to the grounds and buildings, may have influenced his inclination. At thirteen, however, he was reading Herbert Spencer, and in the high school he showed such interest and aptitude in the sciences that he was selected by the teacher to assist with experimental demonstrations to the class.

At the university, after trying mathematics and finding that to him "the whole mathematical scheme was very mysterious" and after having "a terrible time" with languages, he "stuck, therefore, to the biological sciences for the most part, with excursions into literature, philosophy, and other directions that aroused my interest at the time." He was given a position as student assistant in the physiology laboratory and in the department of anatomy. He studied the brain with Professor Wilder and took a course in physiological psychology and lectures in psychology and philosophy. He lived hard, in wretched attic rooms, with indifferent food, on less than five dollars a week. He had neither time nor money to spend on amusements, ten cents being all that he spent one year. His college years were, however, he says, happy ones, and he maintained his health and buoyancy.

His medical course was taken at the Long Island College Hospital and College. As compared with present advantages in medical education, the course was crude and inadequate. That such courses could have produced physicians who became not only successful practitioners, but, in some instances, teachers and scientific investigators of national and international distinction, is remarkable. Attendance at lectures at two winter sessions, with dissecting and a meager introduction to laboratory work, constituted the full course required for the degree of doctor of medicine. Dr. White, therefore, became a graduate physician when he was twenty-one. After a year's interneship in general-medical service, he entered upon his career in psychiatry by receiving an appointment on the staff of the Binghamton, N. Y., State Hospital. He had received no special preparation for his duties there. At the medical college, the instruction in psychiatry consisted of one clinical lecture. At the university he had engaged in studies in psychology and philosophy, but withal, he says, "whatever notions I had as to what constituted psychiatry must have been entirely wrong." He had, however, been well schooled in independent thinking and self-reliance; he had an unquenchable thirst for knowledge and a great interest in human life, and an irrepressible persistence. He had also, he says, been much influenced by the superior character and attainments of some of his teachers in school, university, and medical college and hospital, and

had learned that "love and respect must have worthy objects in order that we ourselves may be worthy."

He worked hard, he says—"night and day, as a matter of fact. I read everything in the library, often sitting up well into the night to do it." He found the patients "tremendously interesting." He spent a large part of the day on the wards, making rounds sometimes four or five times a day, and visiting the receiving ward about midnight.

He entered the field of psychiatry at the dawn of a period of great advances in medicine and psychiatry, and more particularly in the standards and practices in administration and in the study and treatment of the mentally ill in the hospitals of the state of New York. He "sensed the fact that not a few physicians went into a state hospital as a sort of cloistered existence which enabled them to escape the real buffetings of the world," and he determined that this should not be so in his career. He, therefore, took on many more activities than were required of him. He made autopsies, worked in the laboratory, taught in the newly established school of nursing, and collaborated earnestly in improvements that were being made in the facilities and administration of the hospital. He joined the local medical society and participated actively in its proceedings. He studied French and German by correspondence courses, although it was "tremendously laborious work because I disliked the study of languages." He, nevertheless, gained sufficient proficiency to abstract from foreign journals and, some years later, to translate books.

It was at Binghamton that he formed a lasting friendship with Dr. Smith Ely Jelliffe, with whom he afterwards became associated in literary and editorial work. He also engaged in scientific investigations at the newly established State Pathological Institute, especially with Dr. Boris Sidis in the study of "mental dissociation," using hypnotism. This work with Sidis, by which he learned "to search with an abiding faith in the understandability of psychological happenings," and his intimate relations with patients, with whom he lived as a resident physician, were, he felt, "probably two main factors that pushed me along in the direction of my purpose."

Dr. White had well embarked upon his career as a practicing psychiatrist, hospital administrator, author, speaker, and investigator when, in 1903, at the age of thirty-three, he was appointed medical superintendent of the U. S. Government Hospital of St. Elizabeths at Washington, D. C. He remained in this position until his death in March, 1937. The responsibilities and difficulties of the position were greater than he had previously had experience with. He found that, in the treatment of the patients, mechanical and chemical restraints were extensively employed, and that the attitude of the

administration toward the patients was repressive. He changed all this and introduced the facilities, organization, and methods for which advances in medicine and in the conception of mental illness and its treatment had paved the way. He adopted a building program that was directed not only toward providing additional accommodations for patients, but also toward improving classification and toward furnishing for groups of patients the special facilities and forms of organization required for efficient study and treatment of the particular conditions and problems they presented. He surrounded himself with a group of specialists, for the purpose of providing in the treatment of the individual patient "infinitely more skill than he could possibly have in any other way."

During the World War, the hospital was depleted of most of its able-bodied personnel. At the same time, the admission rate nearly doubled, and it was necessary to provide instruction and training for young physicians who were preparing for psychiatric service in the military forces. Twice during his administration the hospital underwent drastic investigations by committees of the U. S. Congress. Disagreeable as they were, Dr. White and his staff endeavored to turn them to good account in the interests of the patients and the work. Not only was the administration vindicated by the investigators, but liberal appropriations were made for the correction of defects, and for the improvement and extension of the service.

Notwithstanding the magnitude and the exacting nature of his problems, Dr. White managed, during the earlier years of his career at St. Elizabeths, to spend five summers in Europe, visiting and studying in the psychiatric hospitals and university clinics and exchanging experiences and views with the leading psychiatrists. He also engaged actively in teaching, writing articles and books, and making addresses, and in consulting and medico-legal work. His vivid account of these activities and his discussion of his experiences, and of conceptions and practices on which he expresses very definite opinions, make fascinating reading and are most instructive and suggestive.

In the last of the three parts into which the book is divided, Dr. White discusses "the goals of the purpose." In three short chapters he deals with the conception of the "organism-as-a-whole," which he expected would soon "modify very greatly the way in which in the future we will deal with many medical issues"; the realistic point of view according to which "ideas are quite as real as chairs and tables," and "the same laws govern in the psychic sphere as in the somatic sphere"; and the rôle of psychiatry, which "emphasizes the psychological aspects of illness, the personality components that are involved, the mental symptoms that go along with the bodily

symptoms; in other words, emphasizes the consideration of the organism-as-a-whole."

In a parting word to hospital psychiatrists, he admonishes them that "character is the most important asset which any man can have who occupies a position of trust." Dr. Wilbur, in his Introduction, extends this thought in interpreting Dr. White's views concerning "those who are socially hard to understand and who are impossible to live with as our neighbors on the open street." He says: "As I interpret him, the only sound base for the future of our race is what we call character, and character of the parent and teacher is more vital to youth than any other factor."

The book is written in simple, non-technical language and can be read with ease and understanding by the "readers of many varieties" for whom it was intended.

WILLIAM L. RUSSELL.

*The New York Hospital.*

THE MIND OF MAN; THE STORY OF MAN'S CONQUEST OF MENTAL ILLNESS. By Walter Bromberg, M.D. New York: Harper and Brothers, 1937. 323 p.

Dr. Bromberg has written a splendid book, scientifically interesting, most readable, and written in good literary style. Throughout, he gives an honest evaluation of the various contributions in the realm of psychotherapy, from those of the ancients to the most advanced psychoanalytic therapies of modern times. The purpose set forth is to view the various trends of psychologic knowledge that have arisen in the past and to correlate them with present-day therapeutic efforts. The tortuous thread of psychotherapy is traced from remote origins through Hippocrates, through the profound psychological therapy of Christ, and through the faith-healing of medieval times to modern psychotherapy. Mesmer, Mary Baker Eddy, Charcot, DuBois, Bernheim, Coué, and others receive interesting and illuminating discussion at the hands of a competent psychiatrist. His search for and his evaluations of their scientific contributions are keen and fair.

There are fifteen chapters, all engagingly titled: Chapter I, *The Roots of Mental Healing;* Chapter II, *Priest and Pagan;* Chapter III, *Kings, Quacks, and Monks: Faith-Healing in Medieval Times;* Chapter IV, *Witchcraft, The Mass Delusion;* Chapter V, *The Devil Loses Dominion Over the Insane;* Chapter VI, *Treatment of Lunacy by Physicians;* Chapter VII, *Mesmer and His Lilac Robe;* Chapter XI, *The Dark Shadow Lifts: The Development of Modern Psychiatry;* and so on.

Chapter VIII, entitled *The Latter-day Faith-Healers,* is a discussion of faith in religion and healing and deals with the revival of spiritualism in America, the transcendentalism of the 1830's, and the psychological background of theosophy, mind cure, and "New Thought." Phineas Quimby is given due credit as the healer whose work formed the basis for the elaborations of Mary Baker Eddy. Her life and progress as a spiritual healer and the psychology of Christian Science healing are interestingly dealt with. The Reverend Mr. Dowie, bread pills, blue glass, and other fads, mind cure, the Emanuel Movement, Eternal Faith, and other pseudo-psychologies, are reviewed and evaluated as symptoms of the cultural growth of the people.

In Chapter XV—*The Future of Psychotherapy*—the author is somewhat fervent in his promises, especially in the matter of psychoanalytic procedures. So optimistic a picture is presented that it is well to balance it with the sobering reflection that our formalized psychotherapy is really but a minute fragment of the vast realm of psychotherapy. Consideration of the psychotherapeutic effectiveness of Oriental philosophies will help one realize this fact. Just as the psychotherapeutic weapons of the ancients matched the culture of their various eras, so our own psychotherapeutic formulation, confused by words and dogmas from many conflicting sources, matches our heterogeneous contemporary culture. We cannot suppose that any psychotherapy in its present formulated structure can survive long. There are those who believe that psychoanalytic therapeutic concepts are already giving way, here and there, before the advances of biochemistry, electro-physiology, and the newer treatments based on the revelations of the laboratory and of scientific medicine. Healing has always been bound up with the identification of the healer with some great spiritual power, and even in our present, more advanced psychotherapeutic efforts, the scientific truth is so often confused by a multiplicity of magic terms and phrases that the common man, and even the physician trained in scientific matters, finds himself bewildered and unable to extract from the psychological writings of our time a really practical psychotherapy. The modern physician usually makes an honest effort to penetrate the mass of controversial psychopathologic and psychotherapeutic data and, failing to find the revelation of a practical technique, rejects the whole thing as the invention of metaphysicians and faith-healers and returns to his bromides and placebos for the treatment of the majority of his patients, perhaps never fully aware of the fact that his strongest weapon is the patient's identification of the physician with some great spiritual force.

The book is interestingly written; the material is well organized; there are nineteen illustrations of considerable interest, a splendid bibliography covering fourteen pages, and a useful index. It is difficult to criticize the volume from any point of view. Yet the thought constantly recurs that the author promises more than psychotherapy can deliver. He implies, though he does not elucidate, the application of Freudian psychoanalysis to the psychoses. The implication is that all mental ills are to be relieved, and then one is somewhat let down by the hint that the whole answer is psychoanalysis. The subtitle—*Man's Conquest of Mental Illness*—would lead the reader to believe that the book contains a thoroughgoing discussion of all the modern techniques of treatment. Yet the relative neglect of many of them becomes obvious to any one searching through the text for a discussion of modern treatment. Approximately sixty pages are devoted to psychoanalysis in comparison to only a few pages devoted to other forms of therapy. The more appropriate, but somewhat less euphonious, subtitle might well have been, *A History of Psychotherapy*.

The medical student should read the book for a historical background, not to be found in the usual textbook's list of dates and accounts of the foundings of the various mental hospitals in Europe and America. There is no question but that the historical data are accurate and presented in a style for which Dr. Bromberg is to be congratulated. Psychiatrists will find the book interesting and carefully written, the material skillfully arranged. The general practitioner also will derive much from reference to this book, and the non-medical reader will find it easy reading; its terms are non-technical and the condensations of the theories of Jung, Freud, Adler, Adolf Meyer, Trigant Burrow, Schilder, and other modern authorities are concise and without bias, although the author leaves no doubt in one's mind that he is wholly devoted to the Freudian psychoanalytic concepts in their application to the individual patient, to social problems, and to society in general.

The reader may find it an engaging digression, after reading this splendid study of mental healing that reaches back 7,000 years into history, to contemplate the panorama of contemporary cultures and to read there the history of mental healing still clearly visible in its entirety, from the magic and sorcery of still surviving primitive tribes, the mystic, semi-religious Hexing cults extant in our own country, and the survival of religious faith-healing in Christian Science, to the present highly complicated structure of Freudian psychoanalysis.

HAROLD D. PALMER.

*The Institute of the Pennsylvania Hospital, Philadelphia.*

MAN AGAINST HIMSELF. By Karl A. Menninger, M.D. New York: Harcourt, Brace, and Company, 1938. 471 p.

It is a truism that there are strong forces in human nature springing from a will to live and directed toward self-preservation. These forces manifest themselves openly and proudly and show a sustained vigor even under circumstances so adverse that the admiring on-looker is at the same time perplexed as to what may be their purpose. On occasion there is evidence of the operation of opposing forces which are self-destructive rather than self-preservative. These are most unmistakable when they lead to suicide, but they also reveal themselves in forms less violent and extreme, but still recognizable. Such manifestations are a puzzle to the observer, and in the past they have been regarded as something unusual and as presenting striking exceptions to a general rule.

One of the contributions of Freud to psychology was to show that negative and self-destructive forces in human beings are something more than exceptional, and that they have been underestimated because they operate in secret, hidden alike from the subject and from those who know him. Instead of being exceptional and weak, such drives have such strength and persistence that they frequently offer strong competition to the self-preservative forces. According to Freud, they furnish the motive for much that is anomalous in human behavior, they are involved in the genesis of many mental and perhaps physical illnesses, and they explain the apparently relentless fate which pursues certain individuals with persistent misfortunes. In these latter cases, fate is nothing more than the mystical personification of those secret inner tendencies in the individual which are directed toward the goal of his own suffering and disappointment.

Dr. Menninger takes for his subject these hidden self-destructive tendencies in human nature, and with the aid of psychoanalysis attempts to bring them from concealment into the light of knowledge. The subject has long been one of special interest to the author, and the substance of certain sections of the book have appeared previously as articles in various journals. With characteristic enthusiasm and thoroughness, Dr. Menninger follows his topic on many levels and in many directions. The work is heavily documented and in this respect displays a catholicity of interest that includes, in addition to exhaustive reference to scientific treatise, citations from literature, folklore, and the daily press.

The book is divided into six parts. Part I is a brief setting of the stage, under the caption *Eros and Thanatos.* Part II deals with suicide. Part III discusses, under the heading, *Chronic Suicide,* asceticism, martyrdom, neurotic invalidism, alcoholic addiction, the

psychoses, and antisocial behavior. Part IV, *Focal Suicide,* covers such subjects as self-mutilation, malingering, "polysurgery," and purposive accidents. Part V, *Organic Suicide,* ventures boldly into the nearly virgin field of the psychogenic factors in organic disease. Part VI, entitled *Reconstruction,* briefly outlines the principles and technique of therapy.

Dr. Menninger's thesis is based on the principles of psychoanalysis, and the whole structure of the work depends upon the validity of these principles plus the soundness of their application to his theme. As would be expected from the author's position and reputation, his basic assumptions are wholly in accord with the accepted tenets of psychoanalysis. When it comes to superstructure and ramifications, the steady current of accustomed clinical psychopathology occasionally overflows its banks and threatens the surrounding countryside, but by and large no permanent damage is done. If any extenuation be needed for some loose treatment and oversimplification, let it be said that this is a popular work written for a wide public and for a special purpose. The manner of presentation runs the scale from the scientific to the reportorial, but the style from all angles is clear and flowing and at times of high literary merit. Case illustrations and factual data in general are condensed to give a maximum of meaning with a minimum of tedium. In fact, a book so interesting to read raises at once the suspicion that it must sacrifice something in the way of scientific accuracy. In contrast to the general pattern of consideration *in extenso,* there is in the last section of the book a brief and pertinent discussion of psychotherapy in general, and the technique of psychoanalysis in particular, which is one of the best in the literature.

This work of Dr. Menninger's deserves something more than perfunctory notice. Whatever its defects as a scientific treatise, it should have a more important function in influencing the general knowledge of the reading public. The author has unique gifts of great social importance which enable him to select important new principles in psychopathology, take them out of the study or consulting room, and dress them up for popular acquaintance without sacrifice of important elements of truth in the process.

It is fair to predict that the book will be widely read, and, directly or indirectly, it is likely to be epoch-making as a contribution to the self-knowledge of the average man. In the reviewer's opinion, never again can the insidious self-destructive tendencies in human kind remain so completely hidden as they have been hitherto; they must hereafter be given new and serious consideration in wide fields of individual behavior and social problems.

The present volume is a fit companion to *The Human Mind,* a

well-known previous work by the same author which is perhaps the most popular book in this country for introducing psychiatry to the layman.

MARTIN W. PECK.

*Boston.*

A BIOLOGICAL APPROACH TO THE PROBLEM OF ABNORMAL BEHAVIOR. By Milton Harrington, M.D. Lancaster, Pennsylvania: The Science Press Printing Company, 1937. 459 p.

In a previous book—*Wish-Hunting in the Unconscious*—Dr. Harrington critically studied psychoanalysis, but did not formulate his own approach to the problem of abnormal behavior. In this book he goes on to develop the biologic mechanistic basis of abnormal human behavior. On the whole, it may be stated that Dr. Harrington is better as a critic than as an original thinker, although his book is valuable and provocative.

First, as to the defects of the book. It suffers from the underlying philosophy of the writer, which is to the effect that consciousness is an epiphenomenon, with no real relationship to the activity and conduct of the human being, thus accepting the position of Thomas Henry Huxley. This philosophic approach is merely one of despair. It is difficult to handle consciousness. It cannot be measured easily. It is something measurable only in terms of itself. It is the sum total of sensory and kinesthetic awareness—whatever that may mean—and yet it does not fit into the ordinary schemes of causation and is not easily measured. But it cannot be thrown out because of our lack of understanding or our logical difficulties. By discarding it, one finally gets reduced to the absurdity, which has long since been pointed out, of postulating an unconscious Shakespeare writing his great plays to be performed by an unconscious set of actors for an unconscious audience, and this without impairing the realities of a glorious situation. Moreover, after Dr. Harrington has laboriously kicked consciousness out of the front door, he finally has to readmit it in his discussion, which is mainly *as if* he accepted consciousness as the real value of life. In his discussion of unconscious thinking, he very directly states that consciousness is the basis of mind and that there can be no such term as "unconscious mind," which seems to give away his central position. Thus, consciousness slips in again by the rear door.

The reviewer also believes that Dr. Harrington is too much swayed by what he calls the "law" of parsimony in science. As a matter of fact, there is no such law; it is merely a convenience to establish as few causes as possible. In actuality, there is no one cause to anything. There is a flood of variables which have to be considered, and

the more variables there are included, the greater the structure of results. What he uses as a guiding principle has been discarded in the practical workings of science long ago.

So much for criticism. On the whole, the book emphasizes that pleasure and pain, satisfaction and dissatisfaction—which in turn are created both by the constitution of the individual, the stimuli that flow in on him, and the standards that have been set up in him by the social milieu in which he finds himself willy-nilly—are the leading factors in the production and understanding of abnormal behavior. The emphasis on the biochemical mechanistic background is necessary at the present time. The adherence to things that are provable rather than those that are built up by metaphor, symbol, and adroitness is especially important at this period of psychiatry and psychology.

Dr. Harrington builds up a dynamism of conduct. The steps are discernible without recourse to too dubious inference. One valuable phase of his book lies in the consideration he has given to the absurdity of social requirement, so that an individual may be plunged into difficulties not so much through his own defects as through the abnormal and impossible demands of society. Dr. Harrington emphasizes the fact that unsatisfactory relationships breed a chain of events that finally lead to crime and neuroses, as well as to the minor deviations from satisfactory and satisfying human conduct.

The book suffers from the defect that the author is too much occupied with the desire to contradict and displace the Freudian doctrines. Its value lies in the fact that the one-sidedness of psychoanalysis and the other allied approaches to human conduct needs to be corrected, certainly so far as present-day psychiatry goes, by the vigorous demonstration that man and all his products are biological; that biochemistry, electric currents, and pharmacological experimentation—to cite only a few of the scientific approaches—can explain and also modify human conduct.

ABRAHAM MYERSON.

*Massachusetts Department of Mental Diseases.*

COMMON NEUROSES OF CHILDREN AND ADULTS. By O. Spurgeon English, M.D., and Gerald H. J. Pearson, M.D. New York: W. W. Norton and Company, 1937. 315 p.

This substantial volume of closely written pages marks one of the first attempts to give in textbook form a comprehensive treatise of the neuroses from the psychoanalytic point of view. It differs from the only similar volume, Fenichel's *Outline of Clinical Psychoanalysis,* in being a more superficial and elementary presentation and in omitting discussion of the psychoses. It also, as the title indicates, treats of child problems as well as those of adults. The authors are members of the faculty of Temple University Medical School in Philadel-

phia, Dr. English, a graduate of the Berlin Psychoanalytic Institute, being clinical professor of psychiatry, and Dr. Pearson assistant professor of pediatrics.

The book represents an earnest attempt to consolidate over a comprehensive field a body of psychoanalytic psychopathology which is still too fluid and changing to lend itself readily to such treatment. The authors have been painstaking and in many ways are to be commended for this pioneer work. The arrangement is excellent both for study and for reference. The theoretical presentations, although sometimes sketchy, are sound on the basis of accepted Freudian teaching. It seems, however, that a greater emphasis on ego psychology in the text might have avoided the misconceptions that may arise from an overweighting of the libido theory. The case material is abundant, but on account of limitations of space has to be set forth so briefly as to interfere with its value.

It is no doubt inevitable that in such an extensive undertaking there will be many defects, and this book has its share. For example, the theoretical section is set forth in a dogmatic fashion as if there were in psychoanalysis a fixed body of established truth instead of a series of working hypotheses. In the reviewer's opinion it would have been an advantage to start with the psychoanalytic method, to outline some of the data obtained by use of this procedure, and on this groundwork to set up the theoretical formulations.

The volume is not intended to be a general introduction to the study of psychoanalysis, and a student without previous familiarity with the subject might well be confused and antagonized rather than informed. There is a lack of perspective in the approach to neurotic problems, with the result that the reader may feel that he must know the full psychoanalytic implication in a given case or be helpless before it. A presentation that kept more in focus the gross psychopathology of the older psychiatry, and supplemented it with the microscopic extension furnished by psychoanalysis, would in many ways be preferable. In a work that covers so wide a field, the discussion of therapy must necessarily be inadequate, but here, particularly in the section on children, there is recommendation for formal analytic treatment in a fashion too wholesale to be helpful.

The book was written by teachers for the use of serious students and not for the casual reader. It should have its most valuable place as a text to supplement an intensive lecture course on psychoanalytic psychiatry, although it will in no way be a substitute for available source material. The volume should also be useful for ready reference by the practising analyst, particularly in the early years of his experience.

MARTIN W. PECK.

*Boston.*

FREUD AND MARX: A DIALECTICAL STUDY. By Reuben Osborn, with an Introduction by John Strachey. New York: Equinox Coöperative Press, 1937. 285 p.

This book, designed for Marxians, is an inquiry into how the Marxian "psychological discoveries" may be deepened and implemented by admitting into the Marxian system of thought the Freudian discoveries with respect to the unconscious mind. As the author shows, the Marxian discoveries seem to have been reached by a process of deduction from an intuitive first principle, the conception of dialectic materialism. This brilliant intuition with respect to the productive process by which man has created what he calls the world of "reality" did in fact lead to the discovery of psychological views which are very close to some of those we associate with psychoanalysis. However, the Marxian system of thought deserves the name of science only in the sense in which we apply the word to Euclidean geometry, and represents a different order of thing from the inductive science of psychoanalysis. Besides this, it is a program of action designed to alter the world of "reality" in terms of a particular world view, fixated at the level of enlightenment of the middle of the nineteenth century.

Mr. Osborn is correct in perceiving that this program must be based on a fuller understanding of the psychological problems involved—the problem of why and wherein this humanly created world has failed to produce the satisfactions aimed at; the problem of whether it has not, in fact, produced new causes for more and more bitter dissatisfaction; the problem of whether this is not necessary and inevitable. These are all problems that any program for reform must face and problems that, in their psychological aspects, depend, in part, on the workings of the unconscious psychological processes discovered by Freud. Mr. Osborn does not, like so many Marxians, make the mistake of rejecting psychoanalysis as an outgrowth of bourgeois ideology. The same objection has with equal validity been brought against the Marxian system of thought.

The book gets off to a bad start. Its introduction boastfully claims for the book that it is a first step in the direction of showing that the Freudian psychology supports and supplements the Marxian system. This is ambiguous. Whose first step? Neither Mr. Strachey nor Mr. Osborn betrays any evidence of being aware that the question of the mutual relationships of the two systems of thought has been of interest to members of both schools for many years, and that there is a considerable body of literature in German dealing with the topic. Nor is any mention made of the fact that for ten years there has been in existence a political party with its own periodical, now in its fourth year, devoted to promulgating the "dialectic-materialistic sexual

science.'' That it became necessary for its founder, a brilliant psychoanalyst, Reich, to split off from the analytic movement, is a fact that would seem to merit the attention of Mr. Osborn.

Another of Mr. Osborn's discoveries, acclaimed by Mr. Strachey as perhaps his ''most exciting theoretical'' one, is that of the dialectic nature of psychoanalytic theory. According to the discoverer, the psychoanalysts are quite unconscious of the dialectic nature of their science. Maybe so. However, they have been using the word ''dialectic'' as a descriptive adjective for a number of years. And there are a number of books by analysts and former analysts devoted to describing the dialectic nature of the analytic technique, man's relation to his ideologies, and the dialectic nature of the creative process. One at least of these books is in English—Rank's *Art and Artist*.

But perhaps it is too much to expect care in these matters in a book apparently intended as a primer for young Marxians. Approximately half the book is devoted to an excellent and judicious summary and simplification of Freudian theory. To do this without unwittingly placing the wrong emphasis is something of a feat. The material is taken almost exclusively from Freud's two series of introductory lectures. This is followed by a section devoted to the Marxian views of primitive society, which the author finds to be very similar to Freud's speculations in the same field. Both views are derived from the same material—the phantasies of early anthropological and sociological thinkers. One gathers that the last word was said on this matter by Engels, thus confirming the general impression that Marxians are still unaware that a certain amount of solid factual material has been added by the researches of later anthropologists which make some of the conclusions of Engels look unsound. Freud has never pretended that his thoughts on the matter were anything more than a ''Just So Story.''

There follow chapters on the materialist conception of history, on religion, and on dialectic materialism, where again parallels, some of them very tenuous and superficial indeed, are found between the two systems. As Osborn says, the two systems are two ways of looking at the same phenomena. From this it seems to follow implicitly that both are dialectic-materialistic ways of looking at things. We will not quarrel with this implication since it agrees with what seems to be the fact. The trouble comes when from seeing an identity in the objects of their observation and a similarity in manner of observation, Osborn concludes that the two systems are identical in aim.

Thus, on page 243, we find the statement: ''The psychoanalyst . . . will see psychoanalysis as having its real significance in the contribution it makes to the task of freeing society from the trammels

of capitalist conditions of production.'' On the contrary, he will see nothing of the kind. He will see that the task is one of freeing society from the evils of sexual repression under any sort of economic system whatever. That sexual repression necessarily of itself creates the capitalist system or vice versa, has not yet been shown to be the case. That overthrowing the capitalist system will necessarily produce sexual freedom, does not seem to follow from the experience in Russia. There a transient phase of partial sexual freedom was succeeded by a recrudescence of bourgeois puritanism. The psychoanalyst has already seen in his patients that the unconscious motivation behind much radicalism and Marxism is reactionary anti-sexuality, a fact not brought out in this book.

It is not within the scope of this book to bring out the fact that a moot question to-day in the analytic world is whether the basic conflict is between the primitive organism and the external world, or whether it is primarily between the life and death instincts in the individual, which is only secondarily reflected on to the outer world. The book seems to picture Freud himself as having made a choice between the two alternatives. This, I think, is not correct. He has, it is true, progressed from the first to the second in considering the problem. Yet it is just in the final decision of this moot question that the important questions for political action lie.

The book lays little stress on the active technical side of analysis. Here, if anywhere, lies the real dialectic, not at all in a merely verbal acquaintance with Freudian theory acquired by reading or over the tea table. The dialectic effect arises in living through and experiencing an analysis. How essential this real understanding is in comparison with a merely verbal one is shown in the final chapter, *Some Applications*. Among other things, this chapter deals with questions of leadership and, on the basis of a total misunderstanding of the rôle of the therapist in the analytic situation, gives utterance to purely reactionary and pro-Fascist ideas as to the rôle of the leader. The rôle of the analytic therapist is not that of leader. It was the misunderstanding of this very point that led Jung to split off from Freud.

That this misunderstanding of the situation is fundamental to the book, is shown again in another aspect. A comparison seems to be hinted at between an analytic experience and a social revolution (one is not always sure that it is not between a neurosis and a revolution). Thus the proletariat becomes comparable to the id. The ruling class to be overthrown is obviously the super-ego. The comparison need and can be carried no further. This suffices to show it up. Analysis does not do away with the super-ego, according to present analytic

beliefs. It simply modifies it in the sense of making it more tolerant and less sadistic.

The opinion of this reviewer is that Mr. Osborn has failed in his aim, but not that his aim was misconceived. That psychoanalysis has much to tell us about sociological and economic activities, even possibly to the extent of providing us with more adequate political aims, seems to be true. How and by what technique this is to be done, remains to be discovered. GEORGE B. WILBUR.

*South Dennis, Massachusetts.*

SOCIALIZED MEDICINE IN THE SOVIET UNION. By Henry E. Sigerist, M.D. New York: W. W. Norton and Company, 1937. 378 p.

This book was conceived about 1932. After preliminary study, and two summers in the Soviet Union, the author has undertaken to describe what he saw and what in his opinion has been achieved in the socialization of medicine in the Soviet Union during the twenty years subsequent to the revolution of 1917.

According to the author, the book aims to present and to interpret in an impersonal way the facts as they became alive to him. He admits that he is sympathetic to the principles of the Soviet system, but assures us that this is the result of study and not of emotion. Nevertheless, one has but to read the introduction to this book to realize the ardor with which he endorses socialized medicine, as well as his vehement condemnation of the so-called capitalistic system.

He believes that the philosophy of socialism, as set forth in the Soviet Constitution of 1936, is the highest form of democracy. According to his introduction, his book aims to deal with the attitude of socialized medicine in the Soviet Union to health, to disease, and to science; with the forms of medical services that such a concept involves; and with the place that medicine has "in the new social order."

In the first chapter he discusses the underlying philosophy of socialism as a prelude to a discussion of the revolution and the setting up of a new socialist state, of which present-day Soviet medicine is but a part. He declares that "there is still no communism in the Soviet Union." "It is not yet a stateless, moneyless society that receives from each member according to his ability and gives to each according to his needs," but it "is a socialistic state of workers and peasants," a necessary transition stage in the development toward communism.

According to Article 10 of the Soviet Constitution of 1936, the present economic foundation of the U.S.S.R. involves "the annulment of private property in the implements and means of production and the abolition of exploitation of man by man." As the author points

out, the present régime is based on the philosophy of history, organization, and strategy held by Karl Marx and others.

In short, it would appear that the basic idea behind this philosophy is the elimination of class struggle, in the belief that the proletariat, who own no property, are to organize and form a new state. Such a state constitutes an interlocking trust or corporation, with control vested in the hands of self-appointed leaders or party politicians who, under a dictator, can determine wages and hours of labor, can decide who among the population shall or shall not work, and, with individual initiative and the profit motive eliminated, can distribute or invest profits as they see fit, ostensibly for the benefit of all.

In this connection, however, the author states, on page 62: "To believe that the Soviet state is a dictatorship of the Communist Party is a great mistake. The people can elect whomever they choose, and there are many more non-Party members than Party members in the administration. The Party does not govern the country, it issues policies. It has no legal power, its only power is that of persuasion. Through their higher political education, their integrity and exemplary work, the Party members are able to exert great influence and are leading the people." The trust implied by the author in these remarks evidences his faith in the fitness of a socialistic scheme, a faith that is zealously defended throughout his book.

He seems to waver in this faith, however, when, after pointing out that the Soviet Constitution of 1936 guarantees freedom of speech, press, assembly, religious worship, anti-religious propaganda, inviolability of person and home, secrecy of correspondence, and the right of asylum to foreigners persecuted for defending the interests of toilers or for their struggles for national liberation (whatever the latter may mean), he goes on to say that "the future will teach us whether these rights will remain on paper or whether they will actually be granted to the people and how soon they will be."

It has long been apparent that the background of the evolution of the Soviet Union is different from that of the Western democracies. Very few of the Western countries have ever understood the Russian philosophy, and they have great difficulty in understanding the Soviet scene of to-day, a scene that involves the largest country in the world, with an area of about one-seventh of the land area of the earth and about one-sixth of its inhabitants. Its varying topography and climate, its varying natural and potential resources, coupled with its heterogeneous population, in which there are approximately 180 nationalities, speaking some 150 languages and dialects, raises the question whether the multiplicity of contradictions inevitable in such a vast scene can be disentangled so as to give a true picture of what has been accomplished in twenty years of a new régime.

The author, however, essays the task—more, he attempts to contrast the scene of the Western democracies—and of the United States in particular, with all its many contradictions—with that of the Soviet Union. He begins his book with the comment that Russia was an Oriental empire until 1682, when Peter the Great established an absolute monarchy and swung the empire toward the West. It was thenceforth subjected to European currents of thought. The author touches briefly upon the high lights of Russian history, with special reference to the struggle of the people against an autocratic monarchy for more than two hundred years. This brief review of the struggle of a people for self-expression and freedom, which began early in the eighteenth century, shows that the idealogy behind the form that such self-expression eventually took was deeply rooted in a background of traditional community thought long before the revolution of 1917. It is conceivable, therefore, that the present philosophy of the Soviet Union may be considerably different from that of our own. Without full appreciation of the possibilities of these differences in background, it is hardly appropriate to contrast the present Soviet cultural and social scene, with but two decades of experience behind it, with that of the United States.

The creed of communism, which is said to be the highest form of socialism, has been held from time to time by many groups of people far back into the days of antiquity. In modern times, however, it has assumed the strategy and the philosophy of Karl Marx. Capitalism, on the other hand, is not a faith or a creed; it is a term invented by socialists to describe that which they hate. Since the author contrasts the present American situation, which he classes as capitalistic, with that which he conceives as existing in the Soviet Union, it may not be out of place to enumerate some of the fundamental principles upon which our own cultural and social scheme is predicated.

Our philosophy has not contemplated a rigid form of state or national organization, but, instead, a way of life that may unfold to meet the ever-changing needs and demands of a people. Under such a scheme there is the potential danger of a people temporarily following the leadership of some Pied Piper who has snared an idea from the cloudland of theory, but such mistakes are possible of correction, and have been corrected in the past through the exercise of the fundamental common sense innate in a liberty-loving people, with opportunity for self-expression and self-determination. Our philosophy contemplates that an individual shall not be judged by race, creed, or national origin, but by human qualities of heart, mind, and skill; that laws which every one must obey shall not be made arbitrarily, but shall be the outcome of debate, deliberation, and consultation; that power shall be divided and not concentrated; that

men have a right to live their own lives, provided they do not injure or jeopardize the common weal; and that men and women are privileged to harmonize many allegiances in terms of religious or other beliefs with that of good citizenship.

It is evident on reading this book that every stage in the evolution of modern medicine may be found represented somewhere in the Soviet Union of to-day, from primitive magic rites and religious beliefs, through folklore medicine and empirical practice, to the scientific approach, with its relationship of cause to effect.

The author touches upon the high lights of medical history in Russia, beginning with the reign of Peter the Great, when Western European medicine began to exert its influence through the migration of professional men to the East and, early in the eighteenth century, there was an awakening to the need for medical educational institutions. After Peter's death, efforts toward medical education fell into decay, and it was not until 1764 that a medical faculty was established in Moscow.

During the reign of Catherine, a number of hospitals were established in Moscow and in St. Petersburg, but throughout the country as a whole no organization existed for the care of the sick or the application of preventive measures. To meet this need, commissions were established to advise the provincial governors in medical matters.

A short time after the abolition of serfdom in 1861, the zemstvo, a form of local government, was introduced as one of the reform measures. It was started by contributions and collections from peasants and the gentry, and it administered charitable and other welfare institutions, taking up such problems as the care of the sick; public health, especially the suppression of epidemics; education; and prisons.

The health question, including the treatment of the sick, was soon recognized as a major problem. Since there were no physicians resident in the community, physicians were employed on a full-time basis by the zemstvo, their services being supplemented by the employment of a kind of medical technician called "feldschers." Material facilities and personnel were woefully lacking, and improvisations were necessary. Thus, a physician might be employed by the zemstvo to visit places within the district and to minister to the sick, or he might be stationed in a given place and the sick brought to him. There was no uniformity in the type of service, except the fundamental principle that medical services and public health generally were solely the function of local authorities, and the system was organized on the basis of rendering medical services to a rural population. It was, however, applicable also to industry, since a law enacted in 1866 compelled factory owners to provide medical service for their workers, and one

hospital bed for each one hundred workers. It is apparent that zemstvo medicine paved the way for Soviet medicine in several respects. It created a medical organization and a nucleus of medical stations that could be increased in numbers and improved, and what had been developed as a habit or a custom of the community naturally became crystallized eventually into the laws and regulations of the land. In the larger cities, however, modern medicine flourished during the middle of the nineteenth century, and the medical science of the country was largely in the hands of Russian physicians.

It is evident from all this that what has been called a reform movement had its background in the customs and traditional practices of the people, in so far as medical service is concerned, and that the socialization of Soviet medicine was a natural and inevitable development.

The author points out that the principles of socialized medicine involve the elimination of all profit motives from medical practice. These principles are free medical services available to all; the placing of the prevention of disease in the foreground of all health activities; and the direction of all health activities by central agencies, such as the commissioners of health, with the result that health work can be planned on a large scale.

The social-insurance movement in Russia can be traced back to prerevolutionary days. It was part of the early revolutionary programs, and now extends its benefits not only to insured workers, but to their dependents also, providing medical care and benefits in cases of temporary disability, such as sickness, accident, quarantine, pregnancy, and childbirth. It provides also additional benefits for babies and funerals, and for unemployment, disability pensions, old-age pensions, and pensions to families in case of the death of the bread-winner. The medical service given insured workers is controlled by the commissioners of health, who are responsible for providing such services, the financial means being provided from social-insurance funds.

At the time of the revolution in 1917, Russia was suffering from a serious lack of physicians, and undertook to train additional ones through the establishment of medical schools. Provision was made also for the training of widwives, nurses, and the other technical personnel required to meet the medical needs of the country. The author discusses the measures that have been set up for the protection of various groups of the population as conceived by Soviet medicine, as well as those relating to the protection of individuals.

In summary, the author comments that never before has government had to undertake its task under more devastating conditions. In spite of all the difficulties, he asserts that in the short period of twenty years the Soviet government has succeeded in industrializing

a backward country, in collectivizing agriculture, and in establishing the foundations of a socialistic society. He states that the Soviet Union was the first country ever to attempt the socialization of medicine, the first that has ever considered the protection of all the people's health as a public function of the state. He thinks, however, that much remains to be accomplished in the public-health field. There is a shortage of physicians, of all types of medical personnel, and of medical facilities, particularly in the rural areas. He says that in preparing his book he was primarily interested in the principles of Soviet medicine and in its positive achievements, which represent permanent gains.

The illustrations add nothing to the volume. The appendices, however, furnish factual data that may be of value as references on the organization of various activities in the Soviet Union. There is, for example, a diagram of the administrative structure of the U. S. S. R., and of the health center in collective farms, and translations of decrees of the People's Commissariat of Public Health and of the Central Executive Committee. The appendices include also an outline of the course of instruction of the Moscow Medical Institute; the scale of salaries of medical workers; regulations governing the periodic medical examination of workers employed in hazardous industries; compilations of statistics on communicable diseases; regulations as to the prohibition of abortions and those governing the artificial interruption of pregnancy, maternal state aid to mothers and large families, the extension of maternity homes, nurseries, and kindergartens, and their supervision and financing; an outline of the Maxim Gorky Institute; a list of biological journals published in the Soviet Union; and regulations imposing penalties for violations of decrees.

W. L. Treadway.

*United States Public Health Service.*

What Social Workers Should Know About Illness and Physical Handicap. New York: Family Welfare Association of America, 1937. 78 p.

Mental Hygiene in Old Age. New York: Family Welfare Association of America, 1937. 50 p.

What do social workers need to know about body disturbances? The first of the booklets under review represents an answer recently made by a selected group of fourteen social workers, fifteen doctors, a lawyer, a superintendent of a convalescent home (who does not indicate her professional background), and two rehabilitation assistants. That these thirty-three persons are presumably well qualified to speak is evident from the fact that most of them are associated with well-known institutions and agencies, both public and private,

in or near New York City, and that the Westchester County Council of Social Agencies, through its Health Division, selected them to inform its staff workers "regarding the consequences of the various types of illnesses which occur among their clients." In addition to the lectures, the booklet includes, as an appendix, a brief list of references, prepared by the American Association of Medical Social Workers. The recommended books and articles are grouped under headings that correspond very closely to the topics chosen for the thirteen lectures.

In all but two instances lecturers were teamed, one or more social workers sharing a single topic with a doctor—a method in common use in approved courses in medical social work. It is interesting to note that although, for the most part, the doctor chooses to speak on "the medical aspects" of a disease under discussion, leaving the social aspects to the social worker, the medical lecturers on tuberculosis and on pediatrics talk on "social aspects" and "the rôle of the social worker," respectively. Evident, however, throughout the series is the practical accord of all speakers with Antoinette Cannon, of the New York School of Social Work, who, in her discussion of medical ethics, expresses the opinion that social workers have at times disturbed themselves unnecessarily in their feeling that they need to know what the doctor knows; instead, they need to know "what ails the patient and what must be done about it." Obviously, their knowledge of what ails the patient may be far from technically abstruse, for of the seventy-eight pages of the booklet not more than twenty can be considered informative from the strictly medical point of view. It is "what must be done about it" that concerns social workers most.

Logically enough, even in a culture that has not as yet seen social work whole, an idea that runs as an undercurrent through the lectures of this series is that of the importance, to the person who is dealing with the patient, of a workable philosophy. To a considerable extent, it is upon what the social worker *believes*—her assumptions—that her usefulness depends. To illustrate, in the last analysis "it is the patient who must decide on questions of health," although both doctor and social worker may be available for consultation. Life is worth while "even with a physical handicap." It is "the social worker's task to guide the [cardiac] patient toward a new outlook of equanimity and temperance." To make a fairly useful and happy citizen of the cardiac patient there must be "more emphasis on and understanding of his emotional and psychological needs in relation to his physical condition." In approaching the venereal diseases, the social worker must have "an objective attitude." "Tact and skill are necessary to help [the

patient] accept the facts and overcome his defense reactions." The social worker must "find ways of calling out the reserves of personality in both handicapped children and their families." "Social workers are learning to accept limitations in themselves, in other people, in environment, and in social institutions." "The social attitudes of our culture are subtle causes of human wreckage."

It is a doctor who makes the statement: "Emotional disturbance can cause the appearance of sugar in the urine quite as readily as dietary indiscretion."

So much for the belief here expressed in the importance of the social worker's concern with the patient's emotional life, and with cultural attitudes. Her concern with the patient's more tangible resources is assumed in these lectures rather than stressed. She presumably agrees with I. S. Falk's recent statement that "security of income, provision of food, shelter and clothing, and relief of distress contribute to the conservation of both physical and mental health." "It is wiser," says Elizabeth Rice, in speaking of the diabetic, "to spend money on keeping the patient well than to have him readmitted to the hospital." And Marion Rickert expresses the opinion that getting professional medical service to those who are dependent upon public assistance will undoubtedly mean increased cost, but the individual's right to it has been accepted.

A contribution which the medical social worker feels is peculiarly her own is referred to in a talk on the physically handicapped child. The speaker states that the child's emotional response may be due to the particular meaning of the experience of suffering a physical handicap.

One lecture is devoted to the new conception of the place of the convalescent home as a "second-degree hospital." The subject of chronic illness is treated imaginatively. "It seems somewhat ironical," says Sedies Shapiro, "to keep these patients on medication, to try to keep up their courage, and then to deprive them of the essence of well-being—the ability to work and to achieve some measure of self-support."

Gordon Hamilton's short summary is packed with interesting observations. "The emphasis throughout these lectures has been upon the importance of utilizing natural settings, natural resources, and normal experiences." "The best social-work treatment is enabling, not managing, educational, not coercive, teaching the principles of rational living."

It is Miss Hamilton who puts into words the fundamental assumption on which the series of lectures is based—"the importance

of coördinating medical and social planning for the effective treatment of the patient."

The second booklet, *Mental Hygiene in Old Age,* also represents a series of lectures given by a New York group. The speakers, of whom two are social workers and four preface their names with a "Dr.," speak on a subject that seems of increasing importance to us now that we have become aware of the statistician's prophecy that the proportion of aged in our population will, for a time at least, be on the increase. Apparently, about "old age with all its implications of diminishing powers," we still know much too little. The speakers again and again urge us to be "understanding" of the complicated problems involved. And to acquire understanding presupposes not only willingness on our part, but a knowledge of degenerative diseases and of satisfactory substitutes for gainful employment that seems to be as yet non-existent. As Flora Fox says, in speaking of the problem of maladjustment between the aged parent and the child, "there is no large body of experience to guide us." She pleads for a case-work approach and an education of the community in the process of growing old.

The psychoanalyst, Dr. A. Kardiner, who talks on psychological factors in old age, recognizing the anxiety and mutual antagonisms with which our culture is "shot through," asks for more use of mental-hygiene clinics. The activities of the aged "should never abruptly be stopped, but changed in accordance with their altered capacities, for, as long as the individual is alive, in addition to food and love, he needs the opportunity to be both functioning and effective."

From the many mental-hygiene problems that emerge from the Old Age Security program, Gladys Fisher selects six for illustration; her generalizations also indicate discernment. "It has been so firmly inculated in our teaching," she says, "that if a person is thrifty and saves his money, he will be independent, that it is difficult to adjust our thinking to fit modern conditions and realize that this is not necessarily true."

Dr. Bowman, who concludes with advice on conserving "the machine" to make it last as long as possible by simplifying and sweetening life for older persons, gives a useful summary of the actual mental diseases that occur in old age. The attitude of Dr. Zeman, who contributes a paper on physical illnesses and mental attitude, is one of hope that, in spite of the actuality of tissue change in practically every person over sixty, old age may be robbed of some of its fears and many of its terrors. His article is a companion piece to Dr. Bowman's.

Perhaps the most exciting contribution to this very excellent symposium is that of Dr. Cohn, of the Hospital of the Rockefeller Institute for Medical Research, who talks on theories of aging. "Aging is not haphazard," he says. "It is a systematic growth process." "Harmony of performance is maintained throughout the body." "Do we," he asks, "lose with years the ability to utilize oxygen?" If we do, death, it would seem, may be considered as natural and as inevitable as is the withering of a flower.

It is to be hoped that both these booklets will reach the attention of social workers everywhere. Perhaps nowhere else can they in such small compass acquire such understanding of what is required of them in the way of clear thinking and generous feeling.

BERTHA C. LOVELL.

*San Francisco, California.*

THE RELATION OF FUNCTION TO PROCESS IN SOCIAL CASE-WORK. *The Journal of Social Work Process,* Vol. I, No. 1, November, 1937. 150 p.

The appearance of the first issue of *The Journal of Social Work Process,* a book-form publication consisting of articles that express and apply to the several case-work fields the philosophy of case-work practice evolved in the Philadelphia School of Social Work, has great importance for the profession as a whole. Here is an articulation, and a notably lucid one, of a coherent point of view in regard to generic case-work as practiced in specific functional units. It has been achieved through the serious and thoughtful effort of a responsible group of practicing and teaching social workers, who have been thinking together over a period of years around the problem of process. Its psychology derives from that of Otto Rank, whose concepts in regard to the "will" have been applied to the practice of case-work. The profession of social work may well be indebted to the Philadelphia School for their generous sharing of a rich experience.

The contributors to this first issue of the *Journal* represent privately supported agencies in the fields of child guidance, child-placing, family case-work, probation, and medical social work. All of the articles were originally prepared early in 1937, either as theses for the Master-of-Social-Work degree or as articles for a state or national conference of social work, and they grew out of practices current at that time.

Their purpose and common point of view are set forth by Miss Virginia Robinson in the Preface and elaborated by Dr. Jessie Taft in the Introduction.

Out of experience at the Philadelphia School of Social Work, Miss Robinson states, "there has developed an understanding and use of function [in social case-work] which makes possible not only an accurate description of process, but a control of process on a professional level. It has seemed worth while to publish a selected group of papers . . . dealing with this problem."

Dr. Taft finds in social case-work the tendency universal "in all human development to extreme swings from object to subject, from the external, the physical, and the social to the internal, the psychological, and the individualistic." She notes the passing of the "intensely psychiatric, psychological, subjective phase of interest in both client and workers," and sees a renewed emphasis on agency function and concern with process as it relates to function. She finds that all of the papers in this issue of the *Journal* are characterized by two attitudes—an "ignoring of the static and analytic [as exemplified in encouraging the reviewing of past experience by the client, whether for purposes of diagnosis or treatment] and a concentration on the dynamic, on the immediate interaction between the two participants in the activity of asking and offering help," the area of help being determined by the function of the agency.

Social case-work is defined, not as the help that an agency offers, but as the process by which it is given. This process is seen to depend upon the case-worker's understanding of what is involved in giving and taking help, upon her understanding of the client and herself in a particular case-work (helping) situation, and upon her disciplined use of herself in making available the services of her agency to the end that the client may work through to his own best solution of the problem that brought him to her.

Dr. Taft well says, "The approach to social case-work via the *needs* of the individual applicant is an approach that leads to inevitable failure and confusion." The application of psychoanalytic concepts to case-work, bringing as it did a deeper understanding of the client than had been possible previously, too frequently resulted in an urge to do something about his better functioning as a total individual, irrespective of the specific service he sought or the one the agency to which he came was set up to offer. The limiting of service in terms of a defined agency function is a healthy swing away from a growing tendency on the part of case-workers toward diffuse helpfulness in areas and by means of techniques too often imperfectly understood.

I raise the question, however, as to whether too rigid a limiting to the use of the present alone, for both diagnostic and treatment purposes, may not represent another pendulum swing and result in an unnecessary curtailing of the case-worker's opportunity to be

helpful. Clients blocked in their use of an agency by feelings arising out of past experience can be and have been helped by means of a process that has enabled them to see and to feel the connection between what has happened in the past and their feelings in regard to a present situation.

This is in no way to deny the value of the help that comes out of the structure of the interview and the orientation of case-work process to function, but merely to suggest a deepened potentiality for case-work helpfulness in certain situations.

Dr. Taft's distinction between case-work and therapy is a helpful and clarifying one: "in the last analysis a therapist cannot be protected from his patient and his own individual responsibility for what he does in the relationship. The case-worker's responsibility, on the other hand, real as it is, must first of all be to the agency and its functions; only as agency does he meet his client professionally."

Her Introduction and the articles that follow point up most imperatively a need for agencies to define function for themselves and for the clients who come to them, and to give service in relation to a function accepted by both.

Is there an indication in some of the articles that the case-worker's giving up of certain areas and means of helpfulness, and limiting of herself in the manner described, has resulted in a need to magnify the importance of the case-work service to the client—to make of it something more mystical and momentous than it actually is? Although differentiation is made between case-work and therapy, is there apparent in some of the *Journal's* articles a tendency to abandon, in case-work, the purpose and process of therapy, but to retain the intensity of feeling peculiar to it? It may be healthy in this connection to remember that while "the application to a social agency may be regarded as a line of division in a client's life," since "it separates the process of struggle from the process of reorganization," there have been other such lines of division for him, too. He has made other efforts toward reorganization, has sought help of other persons—minister, teacher, friend, social agency, and so forth—and probably continues to do so concomitantly with his use of this agency. Moreover, whereas making a decision is "momentous," involving as it does the whole of the organism, still we make scores of decisions daily. The difference lies, of course, in the fact that the case-worker hopefully understands what is involved in making decisions, in giving and taking help, and acts on this understanding in such a way as to facilitate the client's freer use of a larger self than he had known, in coming to a decision.

One other point. One notes a certain setting up of conditions, a defining of the *sine qua non* of case-work practice. I am thinking

particularly of the article dealing with medical social work and the group relating to child-placing. Miss Gilbert, in her article on the social worker in a hospital, makes the statement that no such social-case-work service as she describes—certainly to be desired in its essentials—"could be initiated or maintained without the wholehearted understanding and support of the directors and management." I suppose the same principle would apply to the practice of case-work in any non-case-work setting, as, for example, the public school. One might well, in casting about for such informed and understanding hospital directors or school principals, have difficulty in meeting the familiar challenge, "Name three!" It is necessary to accept the fact that complete understanding and affirmation will be extremely rare and will be achieved, if at all, by virtue of the case-worker's own courage in defining and holding to her function as Miss Gilbert describes it, and in interpreting her services to the personnel of the agency within which she works when and as she is able. Granted that lack of administrative understanding is a grave impediment to effective case-work practiced in a non-case-work setting, it is a very real and general one and must be recognized and accepted if the service is not to be abandoned entirely.

In relation to the selection of foster mothers, one writer suggests that only those be chosen who are able to believe in and hold to their own child-care standards and still accept and maintain standards considered important by the agency—in other words, foster parents able to share the task of child care with the agency. With this principle one cannot but be in accord, yet in many communities a sufficient number of such foster parents will not be available—and perhaps no foster parent (or person) is consistently able to share. I raise the question whether the case-worker's function may not occasionally embrace helping the foster parents with feelings and factors that are temporarily blocking them in certain phases of the giving of helpful care to a child.

It is a temptation to exceed the space allotted for this review because of the stimulation afforded by every article in this most significant publication for social case-workers. No one associated with the profession can afford to miss it. Succeeding issues of the *Journal*, tentatively promised in the Preface, dealing with the application of the same philosophy in such fields as the teaching and supervision of case-work and the administration of public relief, will be eagerly awaited. Meanwhile, certain case-work convictions here set forth and applied will be gratefully affirmed by a professional group all too familiar with its confusions.

RUTH SMALLEY.

*Chicago.*

EMOTIONAL HYGIENE; THE ART OF UNDERSTANDING. By Camilla M. Anderson, M.D. Philadelphia: J. B. Lippincott Company, 1937. 242 p.

This book is written so simply that its abundance of psychological truth may not appear at once. Its ideas are stimulating, gaining in depth and value according to the reader's own ability to add to its situations and problems, and its theme has a universal appeal. In a "modest effort to improve life's quality, and to enrich it in its satisfactions and acceptability," Dr. Anderson offers thoughtful counsel, illustrating various problems in the emotional life, which she throws into bold relief by drawing from patients in hospitals for the mentally ill. The exaggeration clearly establishes her point, and in addition, may help a little toward a better understanding of mental illness.

One is impressed with the tremendous range of topics packed into the short chapters, several of them only three or four pages long. But the book reads easily and is oriented to the main subject. The aspect of development called spiritual is given a definite, although not an obstrusive, place.

The book is divided into three parts. The first and longest, consisting of eleven chapters, is entitled *Biologic and Social Bases of Behavior*. Here the Freudian concept of regression is accepted, and the concept of sexuality as an expression of the total personality. Mind and body are considered inseparable parts of a whole. The rôle of the endocrines is not neglected. The chapters, *Cutting the Umbilical Cord* (emotional emancipation) and *Why Be Adult?* deserve special mention for their pithy presentation and constructive ideas.

The second and third parts are designed primarily for the use of nurses. The second part, *Personality Adjustments,* starts out with the problems of the nurse as a human being and as a woman, and takes up the problems she encounters in dealing with patients, relatives, colleagues, and so on. It is sound and worth-while reading, although one wishes that the author would not refer to the education of the nurse as "training," and that in Chapter 13 space were given to emotional problems more frequent and worrisome to the nurse than the conquesting Don Juan patient.

*The Emotions in Relation to Special Fields,* as the third unit is entitled, deals with some of the nursing specialities. It is very short, but stimulating, touching upon material that is greatly needed in nursing literature. Psychiatric nursing is discussed in a chapter of sixteen pages, one of the longest in the book, about half of it

being devoted to the historical aspect. It is modern in its plea that the nurse see the patient as a whole, with understanding of his personality as well as of his physical needs.

The book includes chapter and topical indexes; an Introduction by Dr. Ross Chapman, of the University of Maryland; a Prologue and an Epilogue by the author; and cartoon illustrations by Dorothy G. Stevenson.

The work is a compact, easy-to-understand presentation, which, while interesting and perfectly intelligible to the general reader, should prove especially useful to the nurse instructor.

HELENA WILLIS-RENDER.

*Psychopathic Hospital, Iowa City, Iowa.*

WOMAN'S PRIME OF LIFE; MAKING THE MOST OF MATURITY. By Isabel Emslie Hutton, M.D. New York: Emerson Books, Inc., 1937. 150 p.

It is fitting that a psychiatrist—Dr. Hutton, author of the excellent *Sex Technique in Marriage*—should have written about the climacteric period in women. Although there are many who would ascribe all of the symptoms of this basically normal "change" to the minor physical changes that occur, there are others, like Dr. Hutton, who feel that "the climacteric is governed by a host of conditions too numerous to mention, into which enter heredity, environment, and every other circumstance of life." Many women are fearful of the possibilities of insanity at, or following, the climacteric, but as the author points out, mental trouble at the climacteric is rare, "except where there has been a previous mental breakdown."

There are chapters on the physiology of menstruation and the menopause. The disorders of the climacteric are discussed in simple detail and in a reassuring manner. Approximately the latter half of the book is devoted to general and specific advice on hygiene, hydrotherapy, diet, and exercise. The chapters, *The Art of Living, Advice to Husbands, Marital Life and the Climacteric,* and *After the Climacteric,* give much valuable advice.

There are too few simple, direct, authoritative, and up-to-date books on the climacteric period. Many of those in existence show the influence of the popular fallacies that surround the subject. Dr. Hutton has avoided these fallacies, and her book of eminently sound advice is an excellent one to place in the hands of the lay woman.

WILLIAM F. MENGERT.

*University Hospitals, Iowa City, Iowa.*

THE ETIOLOGY OF MENTAL DEFICIENCY, WITH SPECIAL REFERENCE TO ITS OCCURRENCE IN TWINS. By Aaron J. Rosanoff, M.D., Leva M. Handy, and Isabel R. Plesset. (Psychological Monographs, Vol. 48, No. 4.) Princeton, N. J.: Psychological Review Company, 1937. 137 p.

This monograph on the etiology of mental deficiency is a most important and valuable study. It is distinguished for the conceptual framework of its attack, for the care involved in the collection of a large unselected series of cases, for the richness and wealth of new quantitative data and case records which are reported *in extenso*, and for the ingenuity employed in testing various hypotheses. The study is also distinguished for its failure to subject its findings to any critical appraisal.[1]

The basic data consist of I.Q.'s and case histories on 366 pairs of twins with mental deficiency in one or both of each pair. The authors toured the United States and Canada for the purpose of collecting these data. Save for a dozen cases in which both twins could not be reached, and a group of Mongols who were made the subjects of a special report, the available 366 twin pairs represent an unselected and consecutive series. Well over half of the monograph is devoted to the presentation *in extenso* of these data. Many of the case histories are of absorbing interest on their own account. For example, there is Case 91, monozygotic or identical twin sisters, born April, 1894, illegitimate offspring of a probably feebleminded mother, separated while still infants, and placed for adoption in different homes. In July and August of 1914, they were committed to the Massachusetts Reformatory for Women at Framingham. "They came under different names and it was not known either to them or to the institution staff that they were related. They were, however, identical in appearance and behavior to such an extent as to be quite indistinguishable." Both had histories of sexual promiscuity with illegitimate pregnancy, both were feebleminded, both were observed occasionally in epileptic seizures, both were released in 1916, both were unable to adjust outside, and both were recommitted to Massachusetts institutions.

Of the 366 twin pairs with mental deficiency (defined as "I.Q. under 80") in one or both of each pair, 126 were classified as monozygotic or identical, 101 as same-sex dizygotic or fraternal, and 139 as opposite-sex dizygotic. Omitting cases for which I.Q.'s were not available or could not be estimated, we have the following findings: among the monozygotic pairs and among the two groups of dizygotic

[1] A technical and statistical critique of the study, by the present reviewer, appeared in the *Journal of Educational Psychology*, Vol. 29, pp. 374–83, May, 1938.

pairs combined, the I.Q.'s do not differ by more than five points in 64.9 and 17.2 per cent of the pairs respectively. These data are doubtless valid for the purpose of demonstrating that monozygotic twins resemble each other more closely than do dizygotic twins, but they are wholly invalid to support the first major conclusion of the authors that "scarcely more than one-half" of the cases of mental deficiency are of hereditary origin.

The second major conclusion is that cerebral birth trauma is "a factor of the highest importance in the etiology of mental deficiency." In the light of the first conclusion, it is clearly implied, though not explicitly stated, that cerebral birth trauma is a more important factor than heredity. A wealth of evidence drawn from the twin data and from other sources is cited to support the importance of cerebral birth trauma. The presentation of this evidence, however, is involved, uncritical, and dogmatic. After much winnowing of the chaff from the grain, two facts are clear. First, the incidence of epilepsy and of infantile palsies, which are almost always associated with cerebral birth trauma, increases markedly with the severity of the mental deficiency. Hence, cerebral birth trauma would seem to be an etiological factor in the more severe grades of mental deficiency. Second, dizygotic twin pairs resemble each other in the occurrence of epilepsy and of mental deficiency to a greater degree than do ordinary sibling pairs. This proves that non-hereditary factors are important in the etiology of these conditions and, hence, suggests that the non-hereditary associated factor of cerebral birth trauma is also important.

To balance this evidence, two additional facts are equally clear. First, the incidence of epilepsy and of infantile palsies and of both among mental defectives is only 15.5 per cent. Hence, on the above argument, cerebral birth trauma is a probably important factor in only 15.5 per cent of the cases. Second, monozygotic twin pairs resemble each other in the occurrence of epilepsy, of infantile palsies, and of mental deficiency to a much greater degree than do dizygotic twin pairs. This proves that hereditary factors are important in the etiology of these conditions and, hence, suggests that hereditary factors are also important in the etiology of cerebral birth trauma itself.

Keeping in mind some distinctions which are neglected by the authors and stressing the importance of environmental control, this reviewer would restate the findings as follows: First, cerebral birth trauma is a probably important factor in 50 per cent of the lower grades of mentally defective twins with I.Q.'s under 50; in 5 per cent of the higher grades of mentally defective twins; and in less than 5 per cent of the higher grades of singly born mental defectives.

That is, only a very small fraction of mental deficiency in general can be attributed to cerebral birth trauma. Second, the importance of cerebral birth trauma cannot, nevertheless, be overstressed because it is the only factor that is amenable to environmental control. Third, since there are probably some hereditary factors which determine susceptibility to cerebral birth trauma, it must not be inferred that excellent prenatal and intranatal care will provide a uniform protection against cerebral birth trauma.

Finally, the authors present three bodies of data, each of which proves to them that sex is a factor in intelligence, females being slightly favored. The evidence from pairs of opposite-sex twins with mental deficiency in one or both of each pair involves too many dangerous selective factors to be seriously considered. The evidence from 233 pairs of opposite-sex twins of normal intelligence is not statistically reliable. The evidence from a much larger number of opposite-sex siblings of normal intelligence proves to be statistically reliable only when certain arbitrary and improbable assumptions are made. However, combining the data from 233 opposite-sex twins and from 713 opposite-sex siblings and excluding 27 pairs with identical I.Q.'s, this reviewer finds that girls are superior in 54.6 per cent of the 919 comparisons. The departure from chance of 4.6 per cent has a probable error of 1.1 per cent; hence, the difference is significant in a technical and statistical sense. The significance of these results in any broader sense is, of course, diminished by the fact that a very large population is required to establish technical statistical significance.

FRANK K. SHUTTLEWORTH.

*Institute of Human Relations, Yale University.*

## NOTES AND COMMENTS

*Compiled by*

PAUL O. KOMORA
*The National Committee for Mental Hygiene*

# SYMPOSIUM ON MENTAL HEALTH

### Announcement and Program

The Section on Medical Sciences of the American Association for the Advancement of Science will hold a Symposium on Mental Health at its regular annual meeting at Richmond, Virginia, December 28 to 30, 1938.

#### Section Officers

*Chairman:* T. M. Rivers, M.D.; *Secretary:* Malcolm H. Soule, Ph.D.

#### Collaborating Agencies

American Psychiatric Association, United States Public Health Service, Mental Hospital Survey Committee, and The National Committee for Mental Hygiene.

#### Program Committee

*Chairman:* Walter L. Treadway, M.D.; *Vice-Chairman:* Clarence M. Hincks, M.D.; *Secretary:* Malcolm H. Soule, Ph.D. *Members:* Franklin G. Ebaugh, M.D., Roscoe Hall, M.D., Samuel W. Hamilton, M.D., Grover A. Kempf, M.D., Nolan D. C. Lewis, M.D., Abraham Myerson, M.D., James S. Plant, M.D., Harry Stack Sullivan, M.D., and Joseph Zubin, Ph.D.

#### Attendance Open to All

Attendance at the Symposium on Mental Health is not limited to members of the American Association for the Advancement of Science and its affiliated bodies. All who have a serious interest in the subject will be welcome—the lay public, as well as scientific and professional workers.

#### Place of Meetings

Headquarters for the Symposium on Mental Health will be established at the Jefferson Hotel in Richmond, at which the administrative business of the Symposium will be conducted during the conference period.

The special sessions of the Symposium will be held in the auditorium of the Commonwealth Club. The general session will be held at the Mosque.

### Registration

Registrations will be made at the Mosque. A registration fee of $1.00 will admit guests to all the Symposium sessions and to all other sessions of the Association's meeting.

### Administrative Office

All inquiries regarding the Symposium should be addressed to the Administrative Office, Symposium on Mental Health, A.A.A.S., Room 822, 50 West 50th Street, New York, N. Y., Paul O. Komora, Administrative Secretary.

### Hotels, Railroad Rates, etc.

Information regarding hotel accommodations, railroad fares, and other particulars will be furnished on request by the Administrative Office. In view of the large attendance (5,000 or more) expected at the winter meeting of the A.A.A.S., all who plan to attend the Symposium are urged to make their hotel reservations early by writing to the Administrative Office well in advance of the meeting.

### Symposium Sessions

The Symposium on Mental Health will run for three consecutive days, with a morning and an afternoon session each day devoted to special topics, and a general evening session on the last day at which the total Symposium proceedings will be reviewed. Unlike the usual scientific meeting, the majority of the communications will not be read at the meetings, but will be published in advance in a series of six brochures, one for each session. These advance contributions will form the basis of the discussions. Each session will be arranged and conducted under the leadership of section chairmen who will summarize and critically analyze the individual papers, which will then be formally and informally discussed by persons selected by them, to whom the brochures will have been sent for study well in advance of the meeting. In addition, there will be opportunity for general, open discussion at each session. The summarization and analysis of the advance contributions and the formal and general discussions will thus constitute the actual program of each session. All the discussions and summaries will be included, with the advance papers, in the published proceedings of the Symposium, which will be issued by the A.A.A.S. after the meeting and will be available to all at a price sufficient to cover the cost of publication.

## PROGRAM OF THE SYMPOSIUM

### Sectional Session I

**Wednesday, December 28th**

**10:00 A.M.**

Introductory Remarks on the Aims and Scope of the Symposium
By Chairman, Section on Medical Sciences, A.A.A.S.: Thomas M. Rivers, M.D., Medical Director, The Hospital of the Rockefeller Institute for Medical Research, New York, N. Y.

### Orientation and Methods in Psychiatric Research

***Session Program***

I. Discussion, Critique, and Summary of Advance Contributions
By Session Chairman: Nolan D. C. Lewis, M.D., Director, New York State Psychiatric Institute and Hospital, Columbia Medical Center, New York, N. Y.

II. Discussion: The Relationship of Fundamental to Applied Research
Speaker to be announced

III. Discussion: The Need and Method for Integrating the Research Forces of the Country
By William Charles White, M.D., National Institute of Health, Washington, D. C.

IV. General Discussion

***Advance Contributions***

1. Epidemiology a Possible Resource in Preventing Mental Disease
By Haven Emerson, M.D., Professor of Public Health Practice, College of Physicians and Surgeons, Columbia University, New York, N. Y.

2. Facilities for Research: Present Status and Essential Governing Criteria and the Rôle of Academic and Tax-Supported Research
By Charles P. Fitzpatrick, M.D., Clinical Director, Butler Hospital, Providence, R. I.; Lecturer in Abnormal Psychology, Brown University, Providence, R. I.

3. An Evaluation of the Problems in the Field of the Somatic Developmental Disorders
   By Charles R. Stockard, M.D., Professor of Anatomy, Cornell University Medical School, New York, N. Y.

4. Problems Associated with Structural and Physico-Chemical Alterations in the Central Nervous System
   By E. A. Spiegel, M.D., and M. Spiegel-Adolf, M.D., Departments of Experimental Neurology and of Colloid Chemistry, D. J. McCarthy Foundation, Temple University, School of Medicine, Philadelphia, Pa.

5. Convulsive Disorders as a Field for Research
   By S. Eugene Barrera, M.D., Research Associate in Psychiatry, New York State Psychiatric Institute and Hospital, Columbia Medical Center, New York, N. Y.

6. Research Problems in the Field of Clinical Psychiatry
   By David Slight, M.D., Professor of Psychiatry, University of Chicago, Chicago, Ill.

7. Abnormal Behavior in Infancy and Childhood
   By Frederick H. Allen, M.D., Director, Philadelphia Child Guidance Clinic, Philadelphia, Pa.

8. A Problem of Delinquency and the Psychology of the Criminal
   By Paul L. Schroeder, M.D., Director, Institute for Juvenile Research, Chicago, Ill.

9. The Function of Biometric Methodology in Psychiatric Research
   By E. Morton Jellinek, Memorial Foundation for Neuro-Endocrine Research; Research Service, Worcester State Hospital, Worcester, Mass.

## Sectional Session II

**Wednesday, December 28th**

**2:00 P.M.**

### Sources of Mental Disease: Their Amelioration and Prevention

***Session Program***

I. Discussion, Critique, and Summary of Advance Contributions
   By Session Chairman: Abraham Myerson, M.D., Director, Division of Psychiatric Research, Boston State Hospital, Boston, Mass.

II. Discussion: The Genetic and Biological Bases of Mental Disorders
   By Laurence H. Snyder, Ph.D., Professor of Medical Genetics, Ohio State University College of Medicine, Columbus, Ohio

III. Discussion: Preventive Possibilities and Practical Applications in Treatment and Control
Speaker to be announced

IV. General Discussion

*Advance Contributions*

1. Genetics and the Heredity of Mental Diseases, with a Note on Eugenics
   By Clyde E. Keeler, Sc.D., Guggenheim Fellow, Howe Laboratory, Harvard University Medical School, Cambridge, Mass.

2. Syphilis and Mental Disease
   By H. Houston Merritt, M.D., Assistant Professor of Neurology, Harvard University Medical School; Assisting Visiting Neurologist, Boston City Hospital, Boston, Mass.

3. Alcoholism and Mental Disease
   By Leo Alexander, M.D., Research Associate, Boston State Hospital, Boston, Mass.

4. The Vitamins and the Abnormal Mental States
   By Michel Pijoan, M.D., Harvey Cushing Fellow, Harvard University; Research Fellow in Surgery, Peter Bent Brigham Hospital; and Research Associate, Division of Psychiatric Research, Boston State Hospital, Boston, Mass.

5. Fatigue and Mental Illness
   By John W. Thompson, M.D., Research Assistant, Fatigue Laboratory, Harvard University; Research Fellow in Neuropathology, Chemist to the Hygiene Department, Harvard University, Cambridge, Mass.

6. The Relationship of Birth Control to Mental Conditions
   By George Gilbert Smith, M.D., Chief of the Urological Service, Massachusetts General Hospital; Urologist, Palmer Memorial Hospital; and Medical Consultant, Massachusetts Birth Control League, Boston, Mass.

7. The Contribution of Child-Caring Agencies in Solving Problems of Mental Disorder
   By Alfred F. Whitman, Executive Secretary, Children's Aid Association, Boston, Mass.

8. Immigration and The Mental Health of Communities
   By J. D. Reichard, M.D., Senior Surgeon, U. S. Public Health Service, Ellis Island, N. Y.

## Sectional Session III

**Thursday, December 29th**

**10:00 A.M.**

## The Economic Aspects of Mental Health

***Session Program***

I. Discussion, Critique, and Summary of Advance Contributions
By Session Chairman: Joseph Zubin, Ph.D., Research Assistant in Psychology, New York State Psychiatric Institute and Hospital; and Consulting Statistician, Mental Hospital Survey Committee, New York, N. Y.

II. Discussion: The Relationship of Mental Health to Medical Economics
By C. Rufus Rorem, Director, Committee on Hospital Service, American Hospital Association, Chicago, Ill.

III. Discussion: The Rôle of Mental Health and Illness in the General Economy
Speaker to be announced.

IV. Discussion: The Economic Sources of Mental Illness
Speaker to be announced.

V. General Discussion

***Advance Contributions***

1. Magnitude of the Problem of Mental Disease
By Carney Landis, Ph.D., Associate Professor of Psychology, Columbia University, and Research Associate, New York State Psychiatric Institute and Hospital; and James Page, Ph.D., Department of Psychology, University of Rochester, Rochester, N. Y.

2. Economic Loss Due to Mental Disease in New York State and the United States, 1937
By Horatio M. Pollock, Ph.D., Director, Bureau of Statistics, New York State Department of Mental Hygiene, Albany, N. Y.

3. Cost in Relation to Standard of State Hospital Care
By William A. Bryan, M.D., Superintendent, Worcester State Hospital, Worcester, Mass.

4. Costs and Organization of Psychiatric Service in the United States
By Michael M. Davis, Ph.D., Committee on Research in Medical Economics, New York, N. Y.

5. Family Care of the Mentally Ill
   By Hester Crutcher, Director of Social Work, New York State Department of Mental Hygiene, Albany, N. Y.

6. The Influence of Economic Factors on Mental Health
   By Benjamin Malzberg, Ph.D., Senior Statistician, New York State Department of Mental Hygiene, Albany, N. Y.

7. Social Security Measures as Factors in Mental Health Programs
   By I. S. Falk, Ph.D., Chief, and N. D. M. Hirsch, Ph.D., Associate, Division of Health Studies, Bureau of Research and Statistics, Social Security Board, Washington, D. C.

8. The Bearing of Emotional Factors on Social-Health Programs for Dealing with Economic Disability
   By H. Flanders Dunbar, M.D., Department of Medicine and Psychiatry, Columbia University, and Presbyterian Hospital, New York, N. Y.

## Sectional Session IV

**Thursday, December 29th**

**2:00 P.M.**

## Physical and Cultural Environment in Relation to the Conservation of Mental Health

***Session Program***

I. Discussion, Critique, and Summary of Advance Contributions
   By Session Chairman: Harry Stack Sullivan, M.D., President William Alanson White Psychiatric Foundation, New York, N. Y.

II. Discussion: The Mental Health Aspect of the Communication of Ideas
   By Gregory Zilboorg, M.D., New York, N. Y.

III. Discussion: Social Migration, Resettlement, and Planned Communities as a Factor in the Promotion of Positive Mental Health
   Speaker to be announced.

IV. Discussion: The Reorientation of Education to the Promotion of Mental Health
   By Lawrence K. Frank, Assistant to the President, Josiah Macy, Jr., Foundation, New York, N. Y.

V. General Discussion

*Advance Contributions*

1. Psychiatric and Cultural Pitfalls in the Business of Getting a Living
   By Edward Sapir, Ph.D., Sterling Professor of Anthropology and Linguistics, Yale University, New Haven, Conn.

2. Some Comparative Data on Culture and Personality with Reference to the Promotion of Mental Health
   By Ruth Benedict, Ph.D., Associate Professor of Anthropology, Columbia University, New York, N. Y.

3. Community Differences and Mental Health
   By Charles C. Limburg, Ph.D., Psychologist, U. S. Public Health Service, Lexington, Ky.

4. Selective Internal Migration: Some Implications for Mental Hygiene
   By Dorothy Swaine Thomas, Ph.D., Director of Research in Social Statistics, Institute of Human Relations, Yale University, New Haven, Conn.

5. Segregated Communities and Mental Health
   By Howard Rowland, Department of Sociology, Pennsylvania State College, State College, Pa.

6. Political Psychiatry: The Study and Practice of Integrative Politics
   By Harold D. Lasswell, Ph.D., Professor of Political Science, University of Chicago, Chicago, Ill.

## Sectional Session V

**Friday, December 30th**

**10:00 A.M.**

## Mental Health Administration

*Session Program*

I. Discussion, Critique, and Summary of Advance Contributions
   By Session Chairman: Clarence M. Hincks, M.D., General Director, The National Committee for Mental Hygiene, New York, N. Y.

II. Discussion: Medico-Legal Aspects of Mental Health Administration
   Speaker to be announced.

III. Discussion: Sociological Aspects of Mental Health Administration

By Ernest W. Burgess, Ph.D., Professor of Sociology, University of Chicago, Chicago, Ill.

IV. Discussion: Mental Health Administration as a Function of Government

By Louis Brownlow, Director, Public Administration Clearing House, Chicago, Ill.

V. General Discussion

*Advance Contributions*

1. Purposes, Aims, Powers, and Duties of a Centralized State Administrative Organization

By Arthur P. Noyes, M.D., Superintendent, Norristown State Hospital, Norristown, Pa.

2. A State Program for the Supervision and Training of the Feebleminded

By C. Stanley Raymond, M.D., Superintendent, Wrentham State School, Wrentham, Mass.

3. Measures Governing the Qualifications for Appointment, Training and Tenure of Office of Those Ministering to the Public Care of the Mentally Ill

By William L. Russell, M.D., formerly General Psychiatric Director, Society of the New York Hospital, New York, N. Y.

4. Practices Dealing with the Admission of Persons to Hospitals for Mental Diseases

By Frederick W. Parsons, M.D., New York, N. Y., formerly New York State Commissioner of Mental Hygiene

5. Psychiatric Expert Testimony

By Winfred Overholser, M.D., Superintendent, Saint Elizabeths Hospital, Washington, D. C.

6. The Mental Patient in Respect to Bona Fide Residence

By Philip Smith, M.D., Chief Medical Inspector, New York State Department of Mental Hygiene, New York, N. Y.

7. Meeting the Needs of the Patient During the First Year of Residence in a Mental Hospital

By Samuel W. Hamilton, M.D., Director, Division of Hospital Service, The National Committee for Mental Hygiene, and Director, Mental Hospital Survey Committee, New York,

N. Y.; and Grover Kempf, M.D., Medical Director, U. S. Public Health Service, and Associate Director, Mental Hospital Survey Committee, New York, N. Y.

8. The Rôle of the Public Mental Hospital with Reference to the Mentally Ill of a Community
   By J. Allen Jackson, M.D., Superintendent, Danville State Hospital, Danville, Pa.

9. Psychiatry in the Community
   By George S. Stevenson, M.D., Director, Division on Community Clinics, The National Committee for Mental Hygiene, New York, N. Y.

10. The Future Outlook and Function of a Local Health Department with Reference to the Mentally Ill of a Community
    By L. M. Rogers, M.D., Surgeon, U. S. Public Health Service, Lexington, Ky.

11. Statistics in Relation to Mental Hospital Administration
    By Horatio M. Pollock, Ph.D., Director, Bureau of Statistics, New York State Department of Mental Hygiene, Albany, N. Y.

## Sectional Session VI

**Friday, December 30th**

**2:00 P.M.**

## Professional and Technical Education in Relation to Mental Health

*Session Program*

I. Discussion, Critique, and Summary of Advance Contributions
   By Session Chairman: Franklin G. Ebaugh, M.D., Professor of Psychiatry, University of Colorado, and Director, Division of Psychiatric Education, The National Committee for Mental Hygiene, New York, N. Y.

II. Discussion: The Rôle of the Internist in Relation to the Mentally Ill
   By Louis Hamman, M.D., Associate Professor of Medicine, Johns Hopkins University, Baltimore, Md.

III. Discussion: The Rôle of the Legal Profession in Relation to the Mentally Ill
   By John B. Waite, Professor of Law, University of Michigan, Ann Arbor, Mich.

IV. Discussion: The Minister and Mental Illness
By Rev. Carroll Wise, Chaplain, Worcester State Hospital, Worcester, Mass.

V. Discussion: Choosing the Medical Student
By Frank L. Babbott, M.D., President, Long Island College of Medicine, Brooklyn, N. Y.

VI. General Discussion

*Advance Contributions*

1. The Criteria of Specialists in Psychiatry and of Facilities for Graduate Work
By C. Macfie Campbell, M.D., Director, Boston Psychopathic Hospital, and Professor of Psychiatry, Harvard University Medical School, Cambridge, Mass.

2. The Present Status of Undergraduate Instruction in Psychiatry in the United States and Canada
By Edward A. Strecker, M.D., Professor of Psychiatry, University of Pennsylvania, Philadelphia, Pa.

3. The Need for Psychiatric Administrators and Its Proposed Solution
By Arthur H. Ruggles, M.D., Superintendent, Butler Hospital, Providence, R. I., and President, The National Committee for Mental Hygiene, New York, N. Y.

4. The Training of Psychologists and Allied Specialists for Mental Health Work
By Simon Tulchin, Ph.B., New York, N. Y.

5. The Present Status of Psychiatric Nursing in the United States and Canada
By G. H. Stevenson, M.D., Superintendent, The Ontario Hospital, and Associate Professor of Psychiatry, University of Western Ontario Medical School, London, Ontario

6. The Public Health Nurse in Potential Relation to Mental Health
By Sybil Pease, Consultant in Mental Hygiene, Pittsburgh Public Health Nursing Association, Pittsburgh, Pa.

7. The Training of Occupational Therapists for Work with Mental Patients
By Eleanor Clarke Slagle, Director of Occupational Therapy, New York State Department of Mental Hygiene, New York, N. Y.

8. The Training of Psychiatric Social Workers

By George S. Stevenson, M.D., Director, Division on Community Clinics, The National Committee for Mental Hygiene; and Katherine Wickman, Pediatric-Psychiatric Clinic, Babies Hospital, New York, N. Y.

## General Session

**Friday, December 30th**

**8:00 P.M.**

Summary and Address

By C. Macfie Campbell, M.D., Director, Boston Psychopathic Hospital, and Professor of Psychiatry, Harvard University Medical School, Cambridge, Mass.

### Research in Mental Hospitals

The importance of research to medical progress is universally recognized. It is axiomatic that without painstaking investigation into the nature and causes of disease, the brilliant achievements of the medical and sanitary sciences in the control and conquest of the scourges and plagues of the past century would not have been possible. This is conspicuously true of scientific accomplishment in the treatment and prevention of physical disorders in man, but it is no less important in the realm of mental disorders, when we consider the magnitude and scope of these disorders and their far-reaching human, social, and economic consequences. The lag of scientific progress in this field in the past, as compared with other fields of medicine, and the reasons therefor, are a familiar story to all students of the problem.

With the recent advances in psychiatry, however, the outlook has changed considerably, and the possibilities and promise of mental medicine are commanding the serious attention of the biological, psychological, social, and other contributory sciences. It is well known now that mental diseases occupy more hospital beds than all other disabling diseases combined. Recognizing the primacy of mental disorders as an institutional problem and its tremendous burden on public taxation, scientists and laymen appreciate as never before the importance of advancing study and knowledge in this field. Indeed, they look upon research as our greatest hope and regard the vigorous prosecution of scientific investigation as imperative, if we are ever to succeed in reducing the incidence of hos-

pitalized mental disorders and bringing them under control. And it is in our tax-supported institutions for mental disease, which care for the great majority of the mentally sick in this country, that such investigation must be especially encouraged and developed.

With this object in view, The National Committee for Mental Hygiene, with the financial aid of the John and Mary R. Markle Foundation, undertook a national survey in order to determine the nature of present investigatory work in tax-supported mental hospitals; of the facilities and resources, actual or potential, that lend themselves to the conduct of such work; and of the steps that can be taken to develop and to extend research activities in these institutions. A report of this study has just been published. It gives us for the first time an outline picture of the research situation in public institutions for the mentally ill, providing, in the words of the report, "a factual basis which will serve as a point of departure and orientation toward the further and more rapid development of research interest and activity in public mental hospitals." As such it should prove of value and interest to scientific investigators, therapists, hospital executives, legislatures, budget-making bodies, and other governmental authorities, and to Foundations and Funds that are turning their attention and financial support increasingly to this promising field of medical science.

The field work of the survey was done by Dr. Charles P. Fitzpatrick, Clinical Director of Butler Hospital, Providence, R. I., and by Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, Washington, D. C., assisted by members of the National Committee's staff. Its findings are interesting and revealing in many respects, and will encourage those who have observed, as most of us have, how little provision has been made for psychiatric research in this country in years past. Actually, the amount and quality of scientific activity in progress in tax-supported mental hospitals at the present time, as shown by the report, are greater than we realized, though yet far short of what they should be in view of the dimensions of the mental-health problem and as compared with research activity in other branches of medicine. But a creditable beginning has been made, and there is tangible evidence of the existence of a potential capacity for research work substantially beyond what we expected to find and requiring only a determined and sustained effort and more liberal financial support to fructify and materialize into actuality.

A limited number of copies of the report will be available, and those interested in securing a copy may address their request to The National Committee for Mental Hygiene, 50 West 50th Street, New York City.

## National Conference on Health and Medical Care

The National Conference on Health and Medical Care was held in Washington in July, at the request of President Roosevelt, with the hope that it would contribute to two ends: first, a better understanding of national needs in the field of health and medical care; second, the formulation of policies that would enable the medical and other professions, private organizations, federal, state, and local agencies, and individual citizens, to coöperate in efforts to meet these needs.

Miss Josephine Roche acted as chairman, and among the 170 participants approximately half represented the "dispensers" of medical and public-health services and the remainder were composed of representatives of labor, agriculture, women's organizations, employers, and other "consumer" groups.

There was presented for the consideration of the conference the findings of a "technical committee on medical care." And the facts submitted included such information as the following: that forty million persons in the United States are living in families with annual incomes of less than $800 and could purchase medical care only at the risk of deprivation of food, clothing, shelter, and other essentials; that individuals with low incomes obtain the smallest amount of medical care; that the death rate is considerably higher for the poor than for the well to do; that 180,000 general hospital beds, 50,000 beds for the tuberculous, and 130,000 for the mentally ill are needed to supplement existing hospital facilities; and that 70,000 lives of mothers and infants could be saved each year through the development of more adequate public-health and medical services.

To meet these needs the technical committee recommended additional annual expenditures for a ten-year period of $850,000,000, of which approximately half should be borne by the Federal Government and half by state and local governments.

This total of $850,000,000 would be utilized for the extension of public-health services, hospital construction, and the provision of public medical care for individuals on relief and for the medically indigent.

Of special interest to workers in the field of mental hygiene is the recommendation of the technical committee that $201,500,000 be appropriated by the Federal Government for mental-hospital construction, including hospital maintenance costs for a three-year period, and an additional $10,000,000 annually for the extension of community mental-health programs.

While no resolutions were passed by the conference, there was agreement that the health and medical needs of the people of the

United States were not being fully met and that suitable measures must be evolved and financed to deal adequately with this critical situation. And because of this agreement on the part of such a representative group, the way has been opened up for future consideration and action on the part of federal, state, and local governments. The conference has, therefore, served a useful purpose and may well prove to be historic.

### Federal Office of Education Studies Problem Children

At the call of John W. Studebaker, Commissioner of Education, fifteen of the nation's leaders in child guidance and adjustment recently attended a conference on the clinical adjustment of behavior problems of school children.

The purpose of the conference, which was held in the Office of Education, Department of the Interior, was to discuss the organization of school systems throughout the United States from the point of view of diagnosing and treating the behavior problems of boys and girls, and to suggest ways in which the Office of Education may help school officials and teachers in cities of all sizes to develop or to improve this type of service.

Specific questions discussed at the two-day meeting included the following:

1. What is a desirable organization for a child-guidance clinic operating under the direction of the board of education?
2. What services are available from clinics operating under auspices other than those of the board of education?
3. What clinical staff is essential for the successful operation of the clinic?
4. What are some of the most effective methods of procedure in referring, treating, and following up cases?
5. What types of behavior difficulties are most amenable to clinical adjustment?
6. How can community resources be coördinated for an effective program of child guidance?
7. How can teachers participate in the activities of the clinic?
8. How can the principles of child guidance demonstrated in the clinic be transferred to the classroom?
9. What is the relationship of the clinical activities of the school system to the general guidance program, and to the program of special education?
10. What special projects have proved successful in individual localities?

Commenting on the conference, and on the one previously held in the Office of Education to discuss problems in the education of

deaf, blind, and socially maladjusted boys and girls in the United States, Commissioner Studebaker said:

> "These conferences have brought together representative leaders in their respective fields. Their major interest is the proper care and education of physically, mentally, or socially handicapped children. In other words, we have pooled the best thinking in this country in an effort to get a clear picture of the outstanding problems faced by schools and clinics in the education of boys and girls who are blind, deaf, and socially maladjusted, or those who need special guidance or adjustment because of abnormal behavior. From these leaders we have gained invaluable information which the Office of Education will now use to help schools and clinics in cities, towns, and rural districts throughout the nation to organize or to develop better services for the child who is abnormal in physical or mental health."

Among those who attended the conference were S. A. Challman, M.D., School Psychiatrist, Bureau of Child Guidance, New York Public Schools, New York, N. Y.; Malcolm H. Finley, M.D., Director, Department of Educational Counsel, Board of Education, Winnetka, Ill.; Roy D. Halloran, M.D., Metropolitan State Hospital, Waltham, Mass.; Zoe I. Hirt, Psychologist and Director, Child Study Department, Public Schools, Erie, Pa.; and George S. Stevenson, M.D., Director, Division of Community Clinics, The National Committee for Mental Hygiene, New York, N. Y.

### Probation Workers Hear Psychiatrist

A continuous effort to bring into one anti-crime front all the forces of social control in the nation was urged by Dr. Lowell J. Carr, Director, Michigan Child Guidance Institute, Ann Arbor, Mich., at the Thirty-second Annual Conference of the National Probation Association, held in Seattle, Wash., this summer.

> "The decline of the family and the face-to-face neighborhood, the disorganization of community mores in modern American life, and the inefficiency of merely legal corrective measures [said Dr. Carr] are throwing increased emphasis on behavior control by extra-legal techniques. Unfortunately this development has usually proceeded piecemeal without adequate orientation to the total situation and without adequate coördination of extra-legal agencies with one another or with the courts.
>
> "The coördinating-council movement represents one important reaction to the obvious need of more unity of effort. But, of course, more unity of efforts is not the only thing needed. There is also need of broader perspectives, more scientific information, more skilled techniques, inter- as well as intra-community organization, and continuous effort to bring into one anti-crime front from the neighborhood to the nation all the forces of social control: local and state governments, the police, the courts, the administrators of our custodial institutions, social workers, the churches, the schools, scientists, the press, and the best lay leadership.

> "During the last four years in Michigan there has been gradually taking form an attempt to mobilize science, social work, the courts, the schools, publicity, community leadership, and governmental support to reduce juvenile delinquency. It is still only an attempt. I cannot point out to you a single community in which the objective has been fully achieved. And, as we all recognize, juvenile delinquency is only one of a score of problems. But there are a number of places in the state where promising beginnings have been made in this restricted field."

As examples of what had been done in his state, Dr. Carr outlined the work being accomplished there by three separate organizations—"a privately supported social-work experiment called the Ann Arbor Boys' Guidance Project; a state supported institution, the Michigan Child Guidance Institute, administratively part of the University of Michigan, but legally separate; and finally a state-wide lay organization known as the Michigan Delinquency Prevention Council."

## Nursery Education

The National Association for Nursery Education has just published the proceedings of its Seventh Biennial Conference held in Nashville, Tenn., last October. "Safeguarding the Early Years of Childhood" was the theme of the conference, which brought together educators, social workers, psychologists, sociologists, health workers, and others from forty-one states, to consider the scientific, social, educational, economic, and political problems in the whole field of child welfare, with special reference to their bearings on young children. Particular emphasis was laid on the need for coördinating all the agencies working in this field. The mental-hygiene implications of these problems, in theory and practice, were discussed extensively by authorities in mental-health work. Attention to such significant topics as coördinated programs of social action in the realms of medicine and education, housing, and resettlement reflected the broad scope of the issues and interests of the conference, and students of child development everywhere will find the material of great value in furthering their studies of the subject. Copies of the report may be obtained at fifty cents per copy from Katherine Roberts, Secretary, Merrill-Palmer School, Detroit, Mich.

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